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January 1980

BALCONY

Journal of the
State Medical
Association

Mississippi

(ISSN 0026-6396)


Contents:

Child Abuse in
Jackson, MS

Ultrasonography of
the Gallbladder



A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Where AMA stands on the issues

While some critics are quick to criticize AMA for being "negative" on health issues, the record shows that in recent years the Association has *supported*, and in several instances developed and submitted for introduction, many pieces of federal health-related legislation.

On preventive medicine .

✓ *Food labeling* Supported improved food labeling to aid patients in properly selecting foods as part of specified dietary regimens or in avoiding foods where a known intolerance exists.

✓ *Alcoholism* Supported the establishment and continuation of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act.

✓ *Drug Abuse* Supported the establishment and continuation of federal assistance for drug abuse education, treatment and rehabilitation programs.

✓ *Communicable diseases* Supported continuation of federal programs of immunization and control of communicable diseases and supported continuation of the Venereal Disease Control Program.

✓ *Disease prevention* Supported legislation authorizing wide-ranging efforts to reinforce programs of prevention, health promotion and health education through federal-state activities.

✓ *Family planning* Supported a program of family planning services under the Family Planning and Population Research Act.

✓ *Health education* Supported a program of federal assistance for the development and operation of health education programs at primary and secondary levels.

✓ *Mental health* Supported legislation calling for a one-year extension of the Community Mental Health Centers Act and a study of programs authorized under it, as well as legislation which would place mental health care on a par with other illnesses under federal programs.

On child care . . .

✓ *Maternal and child care and crippled children's programs* Supported continuation of Title V programs under Social Security and full appropriations for these programs.

✓ *Child immunization programs* Developed and supported legislation strengthening the present immunization program by increasing federal matching funds to states with mandatory child immunization programs.

✓ *Developmental disabilities* Supported an extension and funding of the Developmental Disabilities Act.

On medical research . . .

✓ *Cancer* Supported continuation of the National Cancer Institute and its programs.

✓ *Medical libraries* Supported continuation of assistance programs authorized under the Medical Libraries Assistance Act.

✓ *Biomedical research* Supported establishment of the President's Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offered suggestions for improved legislation.

✓ *Health research and statistics* Supported continuation of the National Center for Health Service Research and the National Center for Health Statistics.

On drugs and devices . . .

✓ *Labeling of drugs* Developed legislation requiring that drug containers dispensed to patients carry the name of the drug, quality and strength, except when otherwise specified by the physician.

✓ *Generic prescribing* Encouraged physicians to prescribe lower cost generic drugs when in the physician's judgment a non-brand name product would be medically appropriate, but opposed legislation mandating substitution of a cheaper generic drug by the pharmacist.

✓ *Food, Drug and Cosmetic Act amendments* Developed and supported legislation which would overhaul the nation's drug laws to improve the system for approving new drug products.

✓ *Medical devices* Supported passage of medical device safety legislation with suggestions for amendments.

✓ *Saccharin* Supported an 18-month delay in banning of saccharin to permit fuller studies and evaluation of its effects.

On physician services . . .

✓ *Emergency medical services* Supported continuation and funding of the Emergency Medical Services Act, authorizing grants to assist in establishment and operation of such systems.

✓ *Rural health care* Developed legislation establishing an Office of Rural Health within HEW and providing assistance for the development and demonstration of rural health care delivery models.

✓ *Indian health care* Supported legislation expanding health care facilities and services and educational opportunities in the health professions for Indians.

✓ *Migrant health* Supported extension of the Migrant Health Center Act program providing health services to migrant workers.

On physicians in government service . . .

✓ *Variable incentive pay* Developed and supported legislation which would make all Armed Forces medical officers eligible for special bonus pay.

✓ *Veterans Administration* Supported legislation

assisting the VA to recruit medical personnel through establishment of comparable pay for all federal physicians.

National Health Service Corps Supported legislation continuing this federal program providing physicians and other health personnel to medical shortage areas.

On health manpower . . .

✓ **Medical manpower training** Supported legislation continuing present programs of federal financial support to schools of medicine and medical students, including construction grants to schools.

✓ **Income tax exemption for scholarships and student loans** Developed a bill encouraging physicians to serve in medical shortage areas which would exempt from federal income tax scholarships and student loans which require service following graduation as a condition of receiving financial assistance.

✓ **Preventive medicine residency** Developed and supported legislation providing for funding under the Health Manpower Act for residency training programs in preventive medicine.

✓ **Foreign medical graduates** To avoid abrupt cut-off of FMGs under the Health Professions Educational Assistance Act, supported an amendment permitting continued limited immigration of FMGs until appropriate provisions can be developed.

✓ **Nurse training** Supported legislation continuing federal support for schools of nursing and nursing students.

✓ **Allied health professions training** Supported legislation continuing federal support of schools and training facilities for the allied health professions and students of allied health.

✓ **Physician extenders** Supported amendments to legislation permitting payment of physicians by Medicare for services of physician extenders in order to foster development of health services in shortage areas.

On Medicare, Medicaid, Social Security and related programs . . .

✓ **Medicare-Medicaid anti-fraud and abuse amendments** Supported increased efforts to halt fraud and abuse in government health programs.

✓ **Medicare-Medicaid** Developed and supported a series of bills which would amend these programs to: (1) allow direct billing of Medicaid patients; (2) delete the Medicare requirement that hospitalization of a patient must occur prior to admission to skilled nursing facilities for reimbursement purposes; (3) establish a more equitable assignment of Medicare fee profile to physicians setting up new practices; (4) limit required utilization review under Medicare only to Medicare beneficiaries and allow Medicare reimbursement for such review; and (5) repeal Section 227 of P.L. 92-603, the provision requiring special Medicare reimbursement for services of physicians in teaching hospitals.

✓ **Physician reimbursement for Social Security disability exams** Developed and supported legislation amending the Social Security Act to provide for reimbursements to private physicians for services in supplying medical evidence needed to evaluate disability claims under Title II.

✓ **Determination of prevailing charges under Medicare** Developed legislation providing for determination of prevailing charge levels for physicians' services without reference to economic index limitations and providing for a more equitable computation of prevailing charge levels.

✓ **Limitation on civil liability of health care providers** Developed and supported legislation preventing malpractice claimants from receiving as part of recovered damages costs of health care services for which payment may be made under Social Security.

On topics of current professional concern . . .

✓ **Hospital cost containment** Objected to the President's proposal to impose a mandatory 9% cap on hospital revenues and urged Congress to allow a private sector program, the Voluntary Effort, aimed at cost control, to continue without federal interference.

✓ **PSRO amendments** Developed amendments correcting some of the undesirable effects of PSRO.

✓ **Laetrile** Supported efforts of the Food and Drug Administration to prevent distribution of laetrile in interstate commerce in the absence of a showing of safety and effectiveness.

✓ **Health planning** Developed and supported legislation to change the National Health Planning and Development Act to insure that required planning decisions are made at the local level with adequate provider input, and to eliminate onerous penalties against states failing to pass certificate-of-need laws.

✓ **Confidentiality** Supported increased protection of confidentiality of physician and patient records generated by federal programs.

On government operations . . .

✓ **Department of Health** Developed legislation establishing a cabinet-level Department of Health headed by a physician.

✓ **Amendments to the Administrative Procedure Act** Developed a bill amending this act to permit a better opportunity for the public to respond to proposed regulations and to provide improved mechanisms for providing affected parties input into the regulatory process.

✓ **Sunset law** Supported legislation requiring a periodic review and rejustification of each federal agency or program to determine whether it should be phased out, changed or continued in its present form.

✓ **Appropriations** Supported appropriate funding for various programs and agencies.

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CONTENTS

ORIGINAL PAPERS

- | | |
|--|---|
| Child Abuse in Jackson, MS | 1 DAVID LEVY, M.D.
Jackson, MS |
| Radiologic Seminar
CXCVIII: Ultrasonography
of the Gallbladder | 4 CARL R. HALE, M.D.
Hattiesburg, MS |

EDITORIALS

- | | |
|----------------------|----------------------|
| New Administration — | 9 CHARLES L. MATHEWS |
| New Hope | |
| Longer Hours and | 9 CHARLES L. MATHEWS |
| Lower Fees | |

THIS MONTH

- | | |
|-----------------------------|--|
| The President Speaking | 8 A Close Look at Political
Involvement |
| Practice Management Mailbox | 12 Consent Requirements in Treatment
of Minors |
| Medical Organization | 13 MSMA Board of Trustees Conducts
Fall Meeting |
| Recollections | 22 From January 1960 JOURNAL
MSMA |

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Treatment of Mild Hypertension Cuts Deaths

Aggressive treatment can reduce deaths by more than 20% in adults with mild high blood pressure. That is the indication of a five-year nationwide study headed by Dr. Herbert Langford, professor of medicine at University Medical Center, who announced the results at the National Institutes of Health in Rockville, MD.

Some 10,940 patients at 13 medical centers (including 900 at UMC) participated in the study, which also found that aggressive treatment of mild hypertension cut stroke deaths by 45% and heart attack deaths by 46%.

The findings are considered very significant to Mississippi, where the death rate from hypertension-related diseases is 23-24% compared to a national average of 14-16% and where some 500,000 people are estimated to have high blood pressure.

Dr. Robert Levy, director of the National Heart, Lung and Blood Institute which funded the investigation, concurs with Dr. Langford's statement that the study removes the uncertainty about the benefits of treating mild high blood pressure.

The director of the State Board of Health's hypertension control program, Dr. Charles A. Cook, reports that only about 11,000 of the state's 125,000 needy patients are currently being served, and he expressed hope that additional funds will be appropriated by the legislature.

Congressmen Vote Against Federal Controls

Mississippi Congressmen Bowen, Hinson, Lott, Montgomery and Whitten were among those voting to defeat President Carter's hospital cost containment bill (HR 2626).

The two and one-half year Congressional debate over cost controls culminated with the House of Representatives adopting a substitute bill by a vote of 234 to 166. The substitute creates a Commission on Hospital Costs which would monitor the voluntary effort to control hospital costs sponsored by the American Hospital Association, American Federation of Hospitals and American Medical Association.

Guardian Society Sets Continuing Education Day

The Guardian Society of the Medical Alumni Chapter of the University of Mississippi Alumni Association will sponsor a Continuing Education Day April 19 in Jackson.

Alumni of the UMC Schools of Medicine, Nursing, Health Related Professions and Dentistry plan separate seminars in their disciplines during the day at the Medical Center. Alumni and other University friends will attend the Continuing Education Day dinner that evening at the Holiday Inn Downtown, says Dr. Wallace Conerly, continuing education day chairman and director of the Division of Continuing Health Professional Education at UMC.

The event, planned to begin at 6 p.m. with a social hour and dinner following at 7:30, will honor 13 Mississippians who were in positions of leadership during the Medical Center's formative years. Guest speaker will be Fifth Circuit Judge J. P. Coleman who was the state's chief executive when the Medical Center was dedicated nearly a quarter a century ago.

"As plans develop, alumni of all UMC schools will receive detailed information about our program. We believe it will be an historic occasion for alumni and the institution," Dr. Conerly said.

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penicillin V potassium

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widely prescribed
brand of oral penicillin



Tablets
125, 250, and 500 mg*
Oral Solution
125 and 250 mg*/5 ml

V-Cillin K[®] penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies

before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

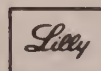
Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

(102175)

***Equivalent to penicillin V.**

Additional information available to the profession on request.



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Eli Lilly and Company
Indianapolis, Indiana 46206

A woman with dark hair tied back, wearing a white chef's coat, is leaning over a large black tray filled with rows of small, golden-brown, elongated food items, possibly fried fish or dumplings. She is looking down at the tray with a focused expression. The background is dark and out of focus, suggesting a kitchen environment. The text "getting back to business" is overlaid in white, bold, sans-serif font on the right side of the image.

**getting back
to business**

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

**for moderate anxiety
with depression**

dual-action
Triavil[®]
containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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*Please see the following page
for a brief summary
of prescribing information.*

by providing symptomatic relief
of moderate anxiety with depression

dual-action[®] Triavil

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:

TRIAVIL[®] 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL[®] 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL[®] 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL[®] 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL[®] 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia), and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia, nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste, diarrhea, parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative
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UMC Adds To Faculty

An instructor and two assistant professors have joined the School of Medicine faculty at the University of Mississippi Medical Center. They are Dr. Ching-Jygh Chen, assistant professor of surgery (ophthalmology), Dr. Anupam Routh, assistant professor of radiology; and Deborah L. Menzel, instructor in obstetrics and gynecology.

Dr. Chen, an ophthalmology resident at Cook County Hospital in Chicago since 1977, earned the M.D. degree at Taipei Medical College in Taiwan. He interned and took residency training at Taipei Veterans General Hospital, and was a clinical fellow at the University of Chicago in 1976.

Dr. Routh, an assistant professor at Rush-Presbyterian St. Luke's Medical Center since 1976, earned the M.D. degree at the National Medical College in Calcutta, India. He was with the cancer control agency in British Columbia from 1974-1975, and senior registrar at the Bristol Radiotherapy Center in England from 1970-1973.

Ms. Menzel earned the B.S. degree in nursing from Vanderbilt University, and the M.S. at the University of Tennessee in Memphis. She had been an instructor at the University of Tennessee School of Nursing since 1978.

UMC Schedules Surgical Forum

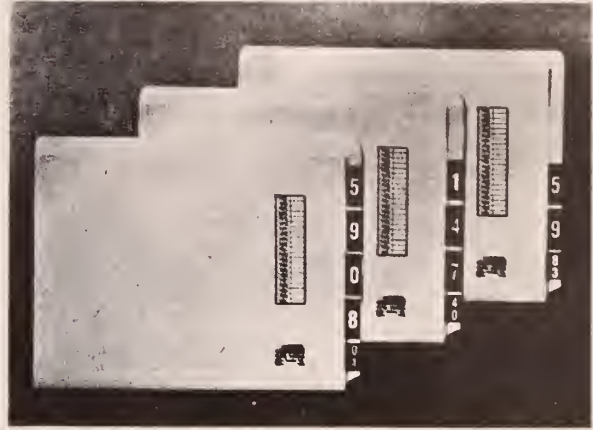
The University of Mississippi Medical Center's seventh annual postgraduate surgical forum is slated for March 13-15 in Jackson.

All sessions will be at the Holiday Inn Downtown. Sponsors are the UMC School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education. Dr. James D. Hardy, UMC professor of surgery and chairman of the department, is course coordinator.

Advance registration is required. Course fee is \$175. The program meets criteria for 17 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. For more information, contact the Division of Continuing Health Professional Education at the Medical Center in Jackson.

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The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.

Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030



NEWSLETTER

January 1980

Dear Doctor:

AMA President Dr. Hoyt D. Gardner cited MSMA's Health Needs Study as an example of voluntary local initiatives for the public good which organized medicine should undertake to meet the problem of eroding public confidence in the profession. Speaking at AMA's Interim Meeting in Honolulu last month, Dr. Gardner also commended Colorado Medical Society's warning on air pollution and Washington State Medical Association's study of the health impact of nuclear power and nuclear waste.

"From state to state, we ought to make active commitments of this kind. This is evidence, for everyone to see, that we physicians do care," he said. These local activities, supplementing the continuing efforts on a national level, represent one part of a three-pronged effort which Dr. Gardner maintains will help restore the public confidence.

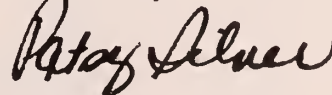
Of primary importance, Dr. Gardner said, is for each physician to make a renewed commitment to his or her position as a prime communicator of the profession on a daily, one-to-one relationship with patients. "The fundamental purpose of this kind of relationship is mutual trust. Our entitlement to it is not something appended to our medical diplomas and status. We have to keep earning it," he said.

A third category of involvement in this mutual effort includes medical families, as exemplified by the many activities of the AMA Auxiliary and its components. "Family life and health in America are better because of what medical families have done to stimulate proper immunization and nutrition, identify and meet other community health needs, and help raise funds for AMA-ERF," he concluded.

The existing "crisis in confidence" in all institutions, especially government, was termed a factor in the deterioration of people's feelings of well-being and happiness, described in a recent survey. Only 30% of American people consider themselves "very happy." Young people were among the least happy. (The increase in teen suicides was called a major health problem in a December report by the Dept. of HHS.)

Of all age groups, the elderly were the most happy, according to the study, in contradiction with the usual picture of the elderly as a very "troubled" segment of society. They may be more carefree, said the investigator, because of better Social Security, pension and medical benefits and because society is meeting the various needs of senior citizens.

Sincerely,



Patsy Silver
Managing Editor

Medicaid Faces Deficit, Considers Reductions

Faced with a possible deficit of \$11 million, the Mississippi Medicaid Commission has given notice of its intent to consider a reduction in current benefits.

The list of reductions numbers some 27 program changes which the Commission may adopt in whole or part. They are:

- Reduce maximum allowable inpatient hospital days from 30 to 20 in each fiscal year — (July 1 through June 30 of each year).

- Eliminate weekend hospital admissions, except emergencies certified by the attending physician.

- Limit hospital outpatient services, including ancillary services (laboratory and x-ray, etc.) to: six dates of service per fiscal year, or twelve dates of service per fiscal year, or eighteen dates of service per fiscal year.

- Require hospitals to bill for physician outpatient services on physicians' claim form and to be reimbursed by physician fee schedule.

- Require hospitals to bill all third parties first and wait 120 days before billing Medicaid.

- Require state institutions (all nursing homes and hospitals) to budget and fund to Medicaid their state funds for federal matching purposes under the Medicaid Program.

- Require hospitals to complete pre-admission tests on an outpatient basis except emergency admissions certified by the attending physician.

- Deny reimbursement for routine standing orders for tests in an inpatient setting and require that all hospital tests be specifically ordered by the attending physician.

- Reimburse hospitals at 60th percentile.

- Reduce maximum allowable physician office visits from 24 per fiscal year to one (1) per month. An additional six (6) visits per fiscal year may be authorized by the Mississippi Medicaid Commission.

- Seek HHR (HEW) approval for an exception under Section 1115 of the Social Security Act for a recipient co-payment of \$1.00 per physician visit.

- Mandate second opinions on surgery except emergencies certified by the attending physician.

- Require all skilled and dual nursing homes to participate in Medicare.

- Limit skilled nursing home care to one hundred (100) days per fiscal year.

- Discontinue intermediate nursing home program.

- Discontinue intermediate mentally retarded nursing home program.

- Require state matching funds for ICF-MR to be put up by participating facility (state or private).

- Discontinue payment for nursing home leave days.

- Require a co-payment of fifty percent (50%) of the payment the Medicaid Program makes for the first day of intermediate care, including intermediate care for mentally retarded.

- Discontinue payment for all over-the-counter (non-legend) drugs.

- Require a 50¢ co-payment on each drug prescription, including each refill, for each Medicaid recipient, except for services provided children through the screening program and for family planning drugs.

- Limit payment to five (5) drug prescriptions in any month for any eligible individual instead of the current seven (7) per month.

- Limit payment for drugs to same as Medicare. (Institutionalized recipients.)

- Discontinue drug program.

- Require a \$2.00 co-payment on each visit by a recipient for dental service, except for services provided children through the screening program.

- Require a \$3.00 co-payment on each pair of eyeglasses except for services provided children through the screening program.

- Require a \$3.00 co-payment on each emergency ambulance trip.

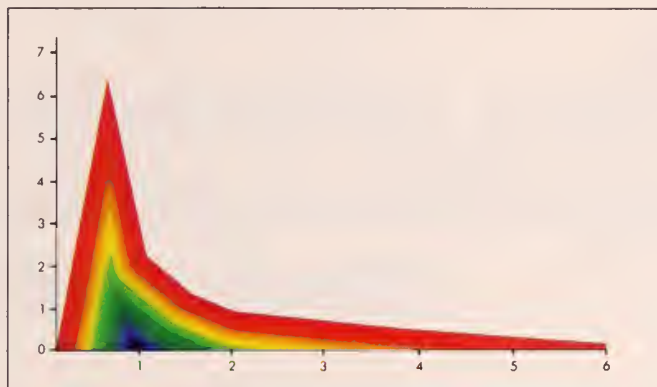
The Commission will hold a public hearing on the proposed reductions on Friday, Jan. 18, 1980, at 2:00 p.m., in the First Floor Auditorium of the Woolfolk Building, Jackson. The 1980 Mississippi Legislature will be requested to provide additional funds for the Medicaid Program and failing this, the reductions finally adopted by the Commission will be initiated after March 1, 1980.

Ultrasound Society Plans Symposium

The Mississippi Ultrasound Society will sponsor a symposium, "Current Applications of Ultrasound in Abdomen and Obstetrics," March 28-29 at the Holiday Inn Downtown in Jackson.

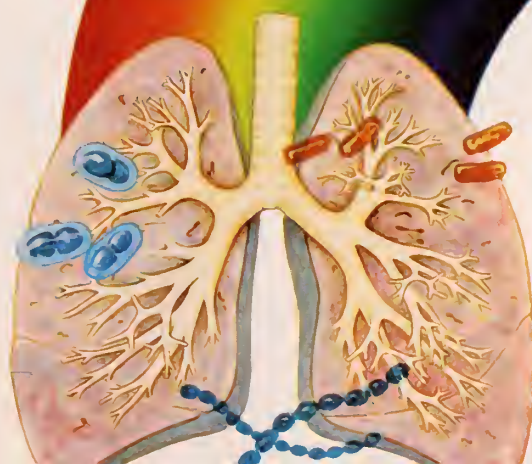
For more information contact John Y. Gibson, M.D., Department of Radiology, University Medical Center, Jackson, MS 39216.

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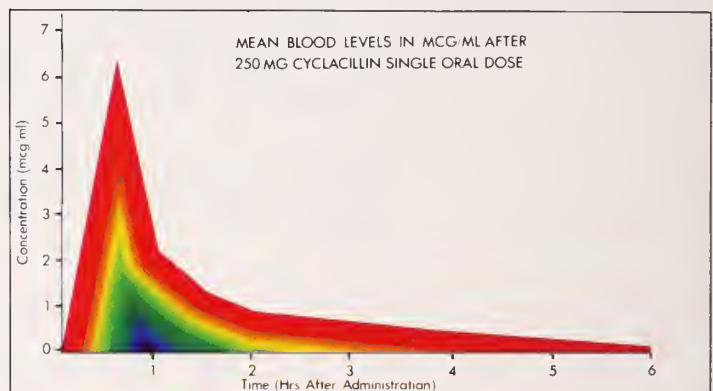
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High cure rate with CYCLAPEN [®]		
Causative Organism	Bronchitis/Pneumonia [†]	No. of Patients
<i>S. pneumoniae</i>	100	73
	95	
Chronic Bronchitis [†] (acute exacerbation)		
<i>H. influenzae</i>	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to <i>H. influenzae</i>	
Streptococcal Sore Throat [†]		
Group A beta-hemolytic Streptococcus	100	44
	86	
<div><div></div> % Clinical Response</div>		
<div><div></div> % Bacterial Eradication</div>		

more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections[†]

*Includes all patients treated. 2,415 evaluated for safety;
1,819 evaluated for efficacy.

[†]Due to susceptible organisms.

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1. Gold JA, Hegarty CP, Deitch MW, Walker BR:
Double-blind clinical trials of oral cyclacillin
and ampicillin, *Antimicrob Ag Chemother*
15:55-58, (Jan.) 1979.

2. Data on file, Wyeth Laboratories.



more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
<i>S. pneumoniae</i>	96	82
	95	
<i>H. influenzae</i>	88	96
	85	
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>		

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Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *O. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

Contraindications
The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

Warnings
CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPI-
CILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED
THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN

ALTHOUGH ANAPHYLAXIS IS A MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL AND INTRAVENOUS THERAPY. REACTIONS ARE MORE LIKELY TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIZATION TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN BEFORE THERAPY WITH A PENICILLIN. CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SEVERE ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, AS IS INDICATED.

Precautions

Precautions
Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cycloclillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cycloacin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated. As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated

hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cycloclillin diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported (See WARNINGS).

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

Dosage and Administration

Dosage and Administration		
INFECTION*	ADULTS	CHILDREN
<i>Respiratory Tract</i>		
Tonsillitis & Pharyngitis**	250 mg q i d in equally spaced doses	Dosage should not result in a dose higher than that for adults body weight < 20 kg (44 lbs) 125 mg q i d in equally spaced doses body weight > 20 kg (44 lbs) 250 mg q i d in equally spaced doses
<i>Bronchitis and Pneumonia</i>		
Mild or Moderate Infections	250 mg q i d in equally spaced doses	50 mg/kg day q i d in equally spaced doses
Chronic Infections	500 mg q i d in equally spaced doses	100 mg/kg day q i d in equally spaced doses
<i>Otitis Media</i>	250 mg to 500 mg q i d in equally spaced doses depending on severity	50 to 100 mg/kg day in equally spaced doses depending on severity
<i>Skin & Skin Structures</i>	250 mg to 500 mg q i d in equally spaced doses depending on severity	50 to 100 mg/kg day in equally spaced doses depending on severity
<i>Urinary Tract</i>	500 mg q i d in equally spaced doses	100 mg/kg day in equally spaced doses

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

*In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Cyclacillin is not indicated in children under 2 months of age

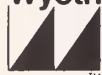
Patients with Renal Failure
Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended

Patients with a creatinine clearance of <50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

In patients with a creatinine clearance of ≥ 10 ml/min or serum creatinine values of ≤ 10 mg %, serum cyclosporin levels are recommended to determine both subsequent dosage and frequency.

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Philadelphia Pa 19101



MEETINGS

National and Regional

American Medical Association Winter Scientific Meeting, January 12-15, 1980, San Antonio, TX; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 1980, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 112th Annual Session, April 27, 1980, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. W. W. East, Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Paul Mink, Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Thomas Waller, Secy., P.O. Box 1487, Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Jancs, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Clyde Allen, Secy., 1245 N. 6th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community Hospital
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

St. Dominic-Jackson Memorial Hospital
Lakeland Drive
Jackson, MS 39216

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

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DATELINE

Marijuana Usage Studied Washington, DC - Marijuana smoking among teenagers has jumped more than 25% since 1976, and today 60% of all high school seniors have tried it at least once. At the time of the most recent government-sponsored survey, about 41 million Americans of 220 million were at least occasional users of marijuana. There is a growing opinion among users that pot is less dangerous than alcohol or tobacco. Drug authorities discussed these facts at November meeting to study its effects.

Blood Services Consolidate Jackson, MS - The Family Blood Assurance Program and Mississippi Regional Blood Center, both headquartered in Jackson but serving areas statewide, were consolidated on November 14, and are now known as Mississippi Blood Services, Inc. Sister Josephine Therese, who was president of Family Blood Assurance, was named president of the new group. Other officers are Delbert Hoseman, first vice president; Chandler Clover, second vice president; Ralph Miley, secretary; and David Levy, treasurer.

MSMA's Placement Service Expands Jackson, MS - An expanded placement service, adopted by MSMA's House of Delegates upon recommendation by the Committee to Study Health Needs, will include several measures to assist communities seeking physicians and physicians seeking practice locations. Periodic meetings will be held for community leaders and interested physicians, an informational packet on recruitment will be made available to communities and a committee will provide evaluation services and placement advice.

ACS Publishes Surgery Factbook Chicago, IL - The American College of Surgeons (ACS) has published its 1979 edition of the "Socioeconomic Factbook for Surgery," which includes descriptive and statistical information on surgical manpower, use of medical services and medical economics. The data are drawn from such sources as the AMA, the American Hospital Association and the Department of Health, Education and Welfare. Free copies are available from ACS, 55 East Erie St., Chicago, IL 60611.

Secretary Harris Commends AMA Chicago, IL - Secretary of Department of Health and Human Services Patricia Harris commended the AMA for its activities which have lead to the reversal of the upward trend in vaccine-preventable diseases. She praised the AMA Auxiliary's promotion programs and other AMA activities in support of state and local immunization efforts, and noted that since the Childhood Immunization Initiative was announced in 1977, the AMA "has been in the forefront of this disease prevention campaign."

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UMC Hosts Spruill Lecturer



Dr. Lawrence Henry Einhorn, center, professor of medicine at Indiana University Medical Center, was the first Spruill Lecturer at the University of Mississippi Medical Center. After his lecture he answered questions from the audience which included Dr. G. Crawley Stubblefield, right, Jackson oncologist, and Dr. Lodovico Balducci, UMC assistant professor of medicine. Mrs. L. Stacy Davidson, Jr., of Cleveland and her sons sponsor the annual lectureship in memory of Mrs. Davidson's parents.

Local Researcher Wins Anesthesiology Grant

Dr. Robert Lewis, assistant professor of anesthesiology at the University of Mississippi Medical Center, has received a grant from the American Society of Anesthesiologists to study the effects of anesthesia and operation on both the classical and alternate pathways of complement activation.

Dr. Lewis received the grant as result of a national competition. He is one of the first grantees to be awarded ASA funds for basic rather than clinical research.

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*0 = No relief 1 = Partial relief 2 = Complete relief

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Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

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MED B-4-S

Congressman Lott Seeks Party Whip Post

Mississippi Congressman Trent Lott is among five Republican House members who will seek the position of party whip when it is vacated next year. Current Republican party whip Robert Michel (IL) has announced that he will seek the position of party leader which is presently held by John Rhodes (AZ), who will relinquish the leadership post after next year.

Nuclear Medicine Organization Elects Dr. Flowers

Dr. W. Mel Flowers, associate professor of radiology and director of the nuclear medicine division at the University of Mississippi Medical Center, has been named president-elect of the Southeastern Chapter of the Society of Nuclear Medicine. He will automatically assume the presidency of the 1,450-member organization next October.

Dr. Flowers is a graduate of Tulane University School of Medicine and completed residency training in radiology at the Medical Center.

A diplomate of both the American Board of Radiology and the American Board of Nuclear Medicine, Dr. Flowers is the author of some 20 scientific articles. His primary research interest is computer applications in medicine.

The Jackson native joined the Medical Center faculty in 1964 as instructor in radiology.

MLA Supports Medical Center



Dr. John F. Busey, left, president of the Mississippi Lung Association, and Robert J. Wells, treasurer and member of the board of directors, presented University of Mississippi Medical Center vice chancellor Dr. Norman C. Nelson, right, with a check which annually supports the Christmas Seal Chair of Respiratory Disease and the training of pulmonary fellows.

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Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

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Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults. Remove foil wrapper and insert suppository into the anus. One suppository in the morning

and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

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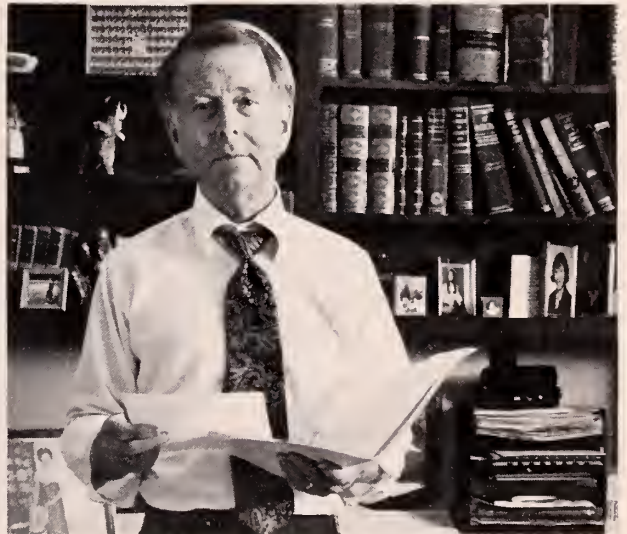
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A thesis summary of 75 to 100 words must accompany each manuscript.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by all authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

ORIGINAL PAPERS

Child Abuse in Jackson, Mississippi

DAVID LEVY, M.D.

Jackson, Mississippi

PHYSICAL ABUSE of children was first described in 1860 by a professor of legal medicine in Paris, France. He described 32 children who were burned and beaten to death.

Approximately one hundred years later (in 1961), Dr. Henry Kempe of Denver, CO, coined the term "Battered Child Syndrome" to describe similar children whose physical injuries were inflicted by their parents, guardians or other caretakers.

Since that time, the pioneer work of Kempe, Helfer, Fontana, Steele and others has resulted in a vast accumulation of knowledge concerning the etiology, treatment and most recently, the prevention of child abuse.

The Child Abuse Prevention and Treatment Act (PL 93-247) which was signed into law on Jan. 31, 1974, established a National Center on Child Abuse and Neglect in the Children's Bureau in the U.S. Department of Health, Education and Welfare.

However, in his commentary, "Abuse of the Child Abuse Law," Bergman¹ writes, "I naively viewed PL 93-247 [The Child Abuse Prevention and Treatment Act] as a vehicle whereby funds for needed treatment would become available. It was not to be. Instead, the bulk of the money provided under the Child Abuse Prevention and Treatment Act has been frittered away on "research," attempts to reinvent the wheel and "educational" programs designed to enhance the incomes of public relations firms and the travel industry."

This is a report of a follow-up study of all the children seen in the pediatric emergency room of the University of Mississippi Medical Center during the

calendar year 1978 who were suspected of having been the victims of child abuse. The specific emphasis of the study was to ascertain what treatment and rehabilitation programs were available to the children and their parents.

During the past year, 72 cases of suspected child abuse were reported in Jackson, MS. The author reports the findings of a follow-up study of 68 of these children, and suggests proposals for developing a comprehensive service delivery system for abused children and their families.

The University of Mississippi Medical Center is the only university teaching hospital in the state. It serves both as a tertiary care center for statewide referrals as well as a primary care center for metropolitan Jackson (population 300,000).

In keeping with the Mississippi Legal Code, physicians are mandated to report all cases of suspected child abuse to the county welfare department and to the judge of the county youth court.

In our study the working definition of child abuse was, "any condition injurious to a child's physical or emotional health that has been inflicted by parents, guardians or other caretakers, or has resulted from their lack of reasonable care and protection."

Initially, the hospital records of all such reported children were reviewed. Subsequent information pertaining to the eventual outcome of each suspected incident of child abuse was obtained from the State Department of Social Services.

During calendar year 1978, 72 cases of suspected child abuse were reported. Follow-up information

From the Department of Pediatrics, University Medical Center, Jackson, MS.

was obtained on 68 children. Regarding age, suspected child abuse was most prevalent in children over the age of 6 years, closely followed by the 0-6 months age group. The youngest child was 2 weeks old, the oldest was 15½ years old, and the mean age was 50 months. (See Table I.) The forms of abuse and the nature of injuries are illustrated in Table II and Table III.

There were two deaths. One was a 2-year-old boy who died following a depressed skull fracture. The other death was a six-month-old infant who was initially reported as suspected child neglect as manifested by failure to thrive. He was being followed by the welfare department, but subsequently died in

TABLE I

Age	No.	%
0-6 months	15	22
7-12 months	7	10
13-18 months	7	10
19-36 months	7	10
3-6 years	14	20
Over 6 years	18	26
Total	68	98

TABLE II

Form of Abuse	No.	%
Physical Abuse	34	50
Sexual Abuse	14	21
Physical Neglect	19	28
Medical Care Neglect	1	1
Total	68	100

TABLE III

Nature of Injury	No.	%
Bruises, Welts, Lacerations	17	25.0
Second & Third Degree Burns	7	10.3
Fractured Skull	8	11.8
Other Long Bone Fractures	2	3.0
Rape	7	10.3
Sexual Molestation	5	7.3
Gonorrhea	2	3.0
Neglect	19	28.0
Medical Care Neglect	1	1.4
Total	68	100

another hospital from a subdural hematoma reportedly following a fall from a couch.

Following the written report of suspected child abuse, a social worker from the division of Child Protective Services of the County Welfare Department evaluates the home situation, and a determination is made as to whether court proceedings before a judge of the county youth court should be instituted.

Of the 68 cases of suspected child abuse, there were subsequent court proceedings in 33. A detailed breakdown of court actions is illustrated in Table IV.

Subsequent Living Arrangements

Forty-eight children were living in their own homes with their parent/s. Of these, 11 had been in an emergency shelter or a foster home for periods varying from ten days to nine months.

Twenty children were living in foster homes. In 14 of the 20, the foster parent was a close relative, e.g., grandmother.

Community Treatment/Rehabilitation Programs

Child Protective Services was the agency primarily involved with the abused children and their families. Visits by the agency's social workers varied from weekly to bimonthly, and continued for periods of time ranging from 2 months to 12 months.

Additionally, some children received services from other community agencies. These agencies and the frequency with which they were involved with the study population are indicated in Table V.

Discussion

Vincent Fontana² has said, "Inadequacy of effort and insufficient expertise at the [Child Abuse] Center and in the office of Child Development have allowed expenditures of limited dollars to carry out needless research, collect information through additional unnecessary surveys, and support conference and educational programs through so called demonstration projects."

The results of our study clearly indicate that whatever the cause, treatment and rehabilitation resources for abused children and their families in Jackson are woefully inadequate. We can only concur with Bergman of Seattle, WA, who writes, "Our greatest frustration is the pitiful lack of treatment resources in the community after the child leaves the hospital."

Our study showed that the only agency consistently involved with abused children and their parents was the Child Protective Services (CPS) division of the County Welfare Department. But the complex and multifactorial origins of child abuse require

TABLE IV

<i>Type of Abuse</i>	<i>No. of Children</i>	<i>No. of Court Appearances</i>
Physical Abuse	34	22
Neglect	19	7
Sexual Abuse	14	3
Medical Care Neglect	<u>1</u>	<u>1</u>
Total	68	33

TABLE V

<i>Agency</i>	<i>Number of Families Involved</i>
Mental Health	13
Rape Crisis Center	1
Parents Anonymous	1
Visiting Nurse, County Health Department	2
Homemaker, County Welfare Department	1
Day Care Center	4
Mississippi Legal Services	4
Fed./State Financial Assistance (W.I.C., A.D.C., Food Stamps)	5

Some families were referred to more than one agency.

more than a social worker from CPS to deal effectively with the problem. Our study shows that not only are community treatment resources meager, but also that inadequate and insufficient use is often made of their services, even when they do exist. For example, a Parents Anonymous group exists in Jackson, but only one family was served by this agency. Similarly, only 13 families received counseling from a mental health agency; only four children attended day care centers and in only one instance was the assistance of a homemaker obtained.

Recommendations

What can be done about child abuse in Mississippi? Forces will have to be mobilized on federal, state and local levels.

On the federal level, in the first four years following enactment of the Child Abuse Prevention and Treatment Act, a total of \$59.1 million was spent. None of this money came to Mississippi. In order to become eligible for funds under the Act, states have to comply with the federal guidelines. Thus, where indicated, Mississippi's child abuse reporting laws, administrative procedures and operating practices should be altered so as to qualify for assistance under PL 93-247.

On a state level, Mississippi does not appropriate any funds specifically for child abuse programs. Clearly, the state will have to make a strong commitment in this direction before any meaningful progress can be made.

On the local level, the University of Mississippi Medical Center should establish a multidisciplinary diagnostic and follow up team. Established programs need to be coordinated so that CPS workers can make more effective use of existing medical, social and legal agencies. Existing programs need to be supplemented in order to develop a comprehensive service delivery system for abused children and their families in Mississippi.

Summary

A follow-up study was done on 68 out of 72 children seen in the pediatric emergency room at the University of Mississippi Medical Center during calendar year 1978. Results indicate how grossly inadequate the community treatment and rehabilitation programs are. Recommendations on federal, state and local levels are presented for the development of a comprehensive service delivery system for abused children and their families in Mississippi.

★★★

2500 North State Street (39216)

References

1. Bergman, A. B.: Abuse of the child abuse law. *Pediatrics* 62:266, 1978.
2. Fontana, V. J.: Testimony before the U. S. House of Representatives, Subcommittee on Select Education of the Committee on Education and Labor, February 25, 1977.

Radiologic Seminar CXCVIII: Ultrasonography of the Gallbladder

CARL R. HALE, M.D.

Hattiesburg, Mississippi

FOLLOWING PIONEER efforts in the development of ultrasonography as a medical diagnostic device by Howry and Holmes in the United States and Donald in Glasgow, and as a result of recent extensive improvement in instrumentation with B-mode or gray scale development, plus widened clinical application by Ross, Brown, Goldberg, Leopold and Alfidi, evaluation of the gallbladder via ultrasonography has gained widespread acceptance and credibility.

Three primary reasons for increasing acceptance of ultrasonography as a diagnostic tool are: (1) It is not invasive. (2) It utilizes no ionizing radiations. (At this time no adverse effects of energy used in ultrasound can be determined experimentally or even projected theoretically by biological studies.) (3) It may provide information which may not be immediately available by other methods.

The basic principle includes utilization of high frequency sound waves. Like light and unlike x-rays, these waves can be focused, reflected, or refracted. The frequencies of sound waves are generated by vibration of a piezo electric crystal in an ultrasound transducer stimulated by an electric signal. The crystal vibrates and responds to an electrical signal, setting up a frequency which is dependent on the shape and thickness of the crystal. Medically useful sound waves are in the range of 2.5 megahertz to 10 megahertz, compared to 20 Hertz to 20 kilohertz waves, representing audible sound waves. The crystal generates a wave for a minute fraction of time, such as 1 millisecond, and listens for the rest of the interval involved to identify returning waves. They are subsequently recorded on an oscilloscope as spikes or on a cathode ray tube as dots.¹

The echoes are produced primarily by the interface between tissues of varying acoustic impedance or resistance to the progression of sound waves.

From the Department of Radiology, Forrest General Hospital, Hattiesburg, MS.

Bone offers the most resistance and air offers the least resistance of the common media medically encountered. The velocity of waves through the medium is directly proportional to the impedance, but the distance that the sound travels through the medium is inversely proportional to its impedance. For example, the progression of sound waves through bone is extremely rapid when compared to air, but the distance traveled is quite short — the energy being effectively dampened by bone impedance.²

There are strong interfaces between tissues that have great differences in impedance such as air and bone adjacent to liquid. However, vessel walls, fat, septa, and parenchyma offer smaller differences in impedance.³

The following is an abbreviated list of velocities, in meters per second, of sound waves traveling through commonly encountered tissues in diagnostic medicine:⁴ air, 332; blood, 1570; bone, 4080; liver, 1549; kidney, 1561; mean value protoplasm, 1440; and muscle, 1585.

Accepted Test

Although some have advocated the use of ultrasonography as the routine survey examination for the gallbladder, in general practice the accepted test is the oral cholecystogram.⁵

From an ultrasonographic anatomical standpoint the gallbladder and biliary tree consist of right and left hepatic ducts, common duct, cystic duct, and gallbladder. The gallbladder is a pear-shaped organ usually in contact with an anterior abdominal wall inferiorly and the visceral surface of the liver superiorly, and oriented in a direction from the cul-de-sac extending cephalad, posteriorly and medially to the Hartmann's pouch.⁶ From the external approach, it lies alongside the level of the right costal cartilage of the eighth and ninth ribs.

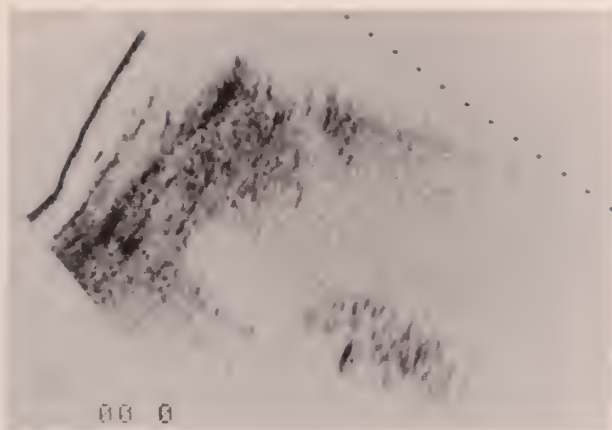


Figure 1

Ultrasonographically, it presents as a fluid filled echo-free structure with the wall images merging imperceptibly into the image of the surrounding liver where the transducer is relatively perpendicular to the wall in question. The exceptions to this relatively nonvisualized wall occur with reverberation and extreme oblique position of the transducer relative to the wall in question. Bile, or gallbladder contents in the normal situation, is generally echo-free. Normal common and hepatic ducts are not imaged or are only very faintly imaged in present technology.⁷

The primary pathological process being sought by ultrasonographic technique is cholelithiasis. This condition and other related conditions will be presented in case and picture image form.

Normal Gallbladder

Figure 1 is the transverse, oblique reconstructed B-mode image of a normal gallbladder showing a pear-shaped, cystic, fluid-filled structure representing gallbladder; excellent through-and-through transmission of sound in an even distribution distal to the gallbladder; thin, relatively echo-free gallbladder walls merging imperceptibly with the homogeneous liver parenchymal pattern; and some fairly good distinction between skin, fat and fascia and muscle planes.

One good image and one plane do not represent a complete examination. A thorough examination of the gallbladder and its possible contents usually requires multiple images taken at $\frac{1}{2}$ to 1 cm in transverse, oblique and longitudinal planes.

Case 1

Figure 2 is a reconstructed transaxial B-mode image of the gallbladder of a 44-year-old female with longtime repeated bouts of epigastric pain followed by clearing and nonvisualized gallbladder on two

attempts at oral cholecystography. A moderately large calculus or cluster of calculi, well visualized in the dependent Hartmann's pouch portion of the gallbladder, is manifested by an echo-reflecting filling defect with reflection of sound and absorption of sound with peripheral shadowing and consistently increased echoes along the gallbladder wall.

At surgery the patient was found to have a clump of adherent calculi, laminated with calcium with cholesterol centers and a thick gallbladder wall due to fibrosis from repeated bouts of cholecystitis.

In this type of presentation ultrasonographic accuracy for identifying calculi or cluster of calculi approaches 100%. The accuracy of ultrasonographic negative studies, as in Figure 1, is not known at this time. It is, however, felt to be quite high.

Case 2

Figure 3 is a longitudinal B-mode image of the gallbladder in a 29-year-old female with unexpected findings. The patient was admitted with pelvic symptoms. During the course of the ultrasonographic examination, local tenderness was noted slightly above the pelvis. The examination was appropriately extended to the area of tenderness, revealing a rather long gallbladder projecting almost into the pelvis and containing a classic pattern of an echo-reflecting filling defect with peripheral shadowing and thick echoes around the wall.

The surgical exploration revealed a dilated gallbladder with thick edematous walls, containing a cluster of calculi plus a cystic mass in the pelvis. Ultrasonography had detected the mass, a papillary cyst of the ovary.

Case 3

Figure 4 is a longitudinal reconstructed image of the gallbladder in a 55-year-old female presenting with severe abdominal pain, nausea, vomiting and known hiatus hernia. Failure to visualize the

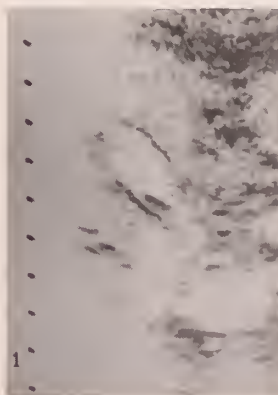


Figure 2



Figure 3

gallbladder had occurred on two attempts at oral cholecystography.

The image shows consistently increased echoes around the wall with very fine, faint, homogeneous echoes toward the dependent portion of the gallbladder, with irregular transmission of sound on the posterior side. This pattern was confirmed on transaxial and oblique images.

Surgical exploration revealed an abnormal gallbladder with a thick, edematous, fibrotic wall containing sludge and some fine, less-than-sand-grain-sized soft calculi.

Although this ultrasonographic evaluation has a high degree of accuracy, it is less accurate than that described in Figures 2 and 3.

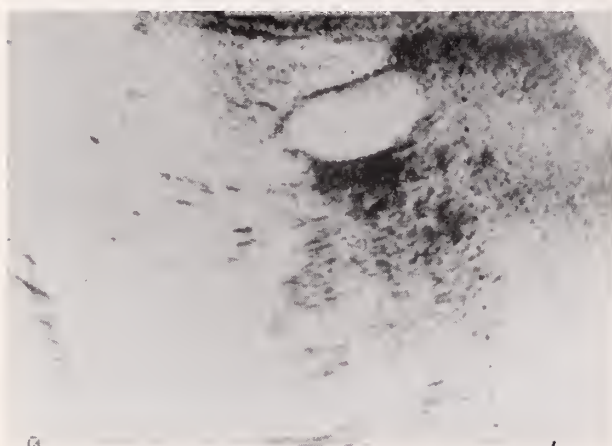


Figure 4



Figure 5

Case 4

Figure 5 is an oblique, reconstructed ultrasonographic B-mode image of the gallbladder area of a 29-year-old female presenting with continuous epigastric pain and nonvisualized gallbladder on oral cholecystography. Multiple oblique, longitudinal and transverse images failed to reveal clear-cut identification of the gallbladder; instead, in the anticipated location of the gallbladder there is a nonhomogeneous group of markedly increased intense echoes with marked peripheral shadowing, indicating a high degree of absorption of sound.

Surgical exploration confirmed the diagnosis of an edematous gallbladder, filled with sludge and soft stones, with a tightly stretched wall and obstruction of the cystic duct.

Case 5

Figure 6 is a longitudinal B-mode image of the gallbladder in a 35-year-old female presenting with continuous abdominal pain alternating from minimal to marked. The gallbladder was nonvisualized on two attempts at oral cholecystography. The patient had significantly elevated alkaline phosphatase, LDH, and bilirubin in both fractions.

The B-mode image identifies a rather large gallbladder, 15 cm in length, containing a cluster of intense echogenic filling defects in the cul-de-sac with layering of smaller defects adjacent to it and increased echoes generally associated with the gallbladder wall. Except for one additional abnormal image, multiple other oblique, transverse, and longitudinal images failed to reveal the echogenic filling defects. This emphasizes the need for multiple sections in multiple planes for precise evaluation of the gallbladder and its possible abnormal contents.

Surgical exploration revealed a hydrops of the gallbladder 14 cm in length containing hard and soft stones and sludge and a thick, edematous, fibrotic wall.

Case 6

Figure 7 is a longitudinal, oblique B-mode image of the gallbladder of a 15-year-old black female with intermittent episodes of right upper quadrant pain and nonvisualized gallbladder on two attempts at cholecystography.

The gallbladder image generally has increased echoes around the wall and a poorly visualized, minimally echogenic filling defect.

Surgical exploration revealed a thick-walled, edematous, fibrotic gallbladder with multiple small, soft stones in the 1 to 2 mm range clustered along the

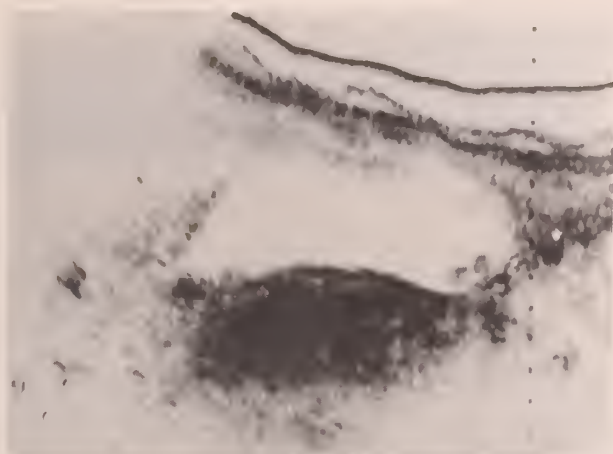


Figure 6

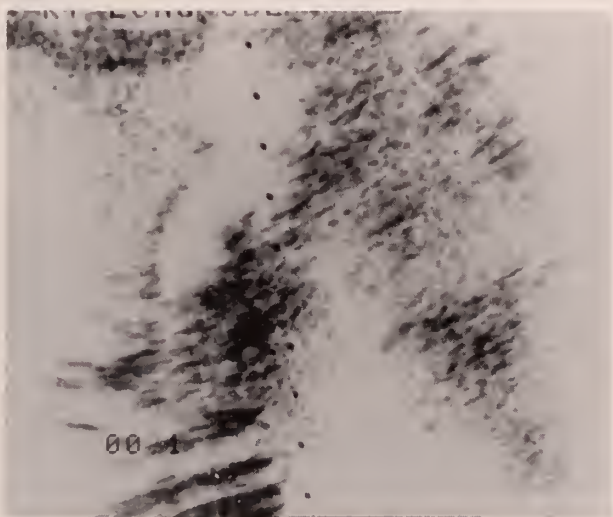


Figure 7



Figure 8

posterior wall, correlating with the ultrasonographic image. No hematologic or systemic disorder generally associated with cholelithiasis could be found on additional clinical evaluation.

Case 7

Figure 8 is a transverse, oblique B-mode image of the gallbladder of an 86-year-old, acutely ill febrile male, presenting with clinical evidence indicating abdominal surgery. There was tenderness in the right upper quadrant, fullness and suspicion of a mass. Ultrasonography was ordered early in the clinical evaluation. The image reveals a long gallbladder with diffuse, increased echoes around the wall and diminished through-and-through transmission of sound. A filling defect is not seen. There is communication of the gallbladder with what appears to be a dilated cystic duct and some other structure containing fluid type material, indicated by minimal diffuse weak echoes and slightly stronger echoes in the dependent portion of the structure.

Laparotomy revealed an abnormal, enlarged gallbladder with edematous, thick, fibrotic walls with a surrounding pericholecystic abscess communicating with the gallbladder, correlating with the ultrasonographic image.

Preoperatively, the ultrasonographic impression correctly identified the condition. However, the nature of this structure as an abscess could only be inferred by the clinical presentation. ★★★

310 South 21st Avenue (39401)

Acknowledgement

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The President Speaking

A Close Look at Political Involvement

GERALD P. GABLE, M.D.
Hattiesburg, Mississippi

As the 1980 session of the Mississippi Legislature gets underway, I think it appropriate that we as physicians take a close look at our political involvement. Traditionally, we have been the leaders of the health care delivery system in this country. We have been looked upon as a learned profession and as unselfish public servants dedicated to the betterment of mankind. Because of the high esteem which our profession enjoyed, we did not have to be very involved in politics.

However, we are being replaced as the leaders of the health care delivery system by the federal government. We are now thought of not as a learned profession but as a part of a major industry as defined by the Federal Trade Commission. Frequently we are looked upon as money-hungry conspirators interested in "ripping-off" our patients, along with private insurers and government-sponsored programs such as Medicare and Medicaid. In this environment and for the protection of our profession we have no alternative but to become more actively involved in politics.

In order to be effective, it will be necessary for us to be properly informed on the issues that confront our profession. We can then become involved in several areas.

First, each of us should know who our elected officials are, and if at all possible, we should make an effort to know them personally. A personal relationship with one's senator or representative goes a long way when the votes are cast.

Second, we should serve as a source of information to our elected officials. We need to offer our expertise to them so that they can be properly informed on issues when decisions are made. It takes only a few minutes to call a legislator and ask if you can be of assistance or if he needs any information on a particular subject. By making such a contact, we will be able to give that person our views on the subject and might possibly be able to influence a vote.

Another way to become involved is through the campaign process. To run an organized campaign in today's society, most candidates use some sort of mass media advertisements. Needless to say, television, radio and newspaper advertisements are expensive. We must be willing to provide our candidates with financial support, and additionally, to solicit financial support from our friends and relatives. We must also be willing to provide personal support. Most candidates are very appreciative of a physician's offer to use his "afternoon off" to take the candidate through a neighborhood to meet voters or through the local hospital to campaign with the employees. Personal support can also come in the form of a letter endorsing the candidate and an offer by the physician or a family member to pass out literature or put a sign in the yard.

If we will each do our part, the expenditure of time and money will not be too demanding on any particular physician. It is only by a cooperative effort and commitment on the part of all physicians that we will be able once again to become the leaders in health care delivery and be thought of as members of the learned profession.

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 1

JANUARY 1980

New Administration — New Hope

This month a new administration takes office in our state. It offers much hope for the future.

William Winter brings to the Governor's Office a record in public service that is unmatched in the state's recent history. He knows state government inside and out. There's never been any question about either his integrity or his sincerity as a public servant.

Brad Dye brings to the Lt. Governor's Office an appreciation for the legislative process which that post requires as presiding officer of the Mississippi Senate. He is a former member of that body, and if that wasn't a good training ground for his new position then he can call on his years of experience in dealing with the legislative process in various offices of state government.

The Mississippi Legislature will have many new faces as the result of retirements and reapportionment. Relatively speaking, it will be a decidedly more urban legislature and perhaps less conservative.

As the 1980s begin, our state still finds itself at the bottom of most socioeconomic indicators. Getting off the bottom will require bold new leadership and action. The administration that assumes the reins of government in our state this month offers much hope in that regard. — C.L.M.

Longer Hours and Lower Fees

The annual "Profile of Medical Practice" recently published by the AMA verifies what many Mississippi physicians have felt for a long time — namely, that they work longer hours, see more patients and charge lower fees than physicians in other parts of the country.

According to the AMA study, physicians in the East South Central Census Tract, which includes Mississippi, Tennessee, Kentucky and Alabama, exhibited the following practice patterns in 1978 as

compared to national patterns (indicated in parentheses).

The average office based physician in our census area practiced 53.2 hours per week compared to a national average of (50.3 hours per week). By specialty the figures were: general practice, 54.9 (49.5) hours; internal medicine, 59.9 (52.8) hours; surgery, 56.0 (53.2) hours; pediatrics, 50.1 (48.8) hours; ob-gyn, 57.7 (51.1) hours; radiology, 46.4 (47.8) hours; psychiatry, 44.8 (45.4) hours; anesthesiology, 49.7 (50.3) hours.

The average office based physician in our census area had 180.8 patient visits per week compared to a national average of (130.6 patient visits per week). By specialty the figures were: general practice, 263.2 (180.0) visits; internal medicine, 120.6 (118.6) visits; surgery, 143.7 (110.8) visits; pediatrics, 188.0 (148.1) visits; ob-gyn and radiology data not available; psychiatry, 49.6 (54.4) visits; anesthesiology data not available.

The average fee for an initial office visit in our census area was \$23.74 compared to a national average of (\$27.60). By specialty the figures were: general practice, \$15.48 (\$16.55); internal medicine, \$33.91 (\$32.53); surgery, \$21.97 (\$26.52); pediatrics, \$17.75 (\$19.03); ob-gyn, \$29.43 (\$29.85); psychiatry, \$47.36 (\$54.63).

The average fee for a followup hospital visit in our census area was \$19.98 compared to a national average of (\$24.21). By specialty the figures were: general practice, \$15.12 (\$17.89); internal medicine, \$22.79 (\$23.95); surgery, \$18.95 (\$23.71); pediatrics, \$16.88 (\$20.30); ob-gyn, \$26.50 (\$24.79); psychiatry, \$34.55 (\$47.09).

The comparisons between our area and the rest of the country are "averages" and as such, bring to mind the old joke that a man with his head in the refrigerator and his feet on the stove is, on the "average," comfortable. The comparisons, along with other data from Medicare and Medicaid, do substantiate, however, what many Mississippi physicians have felt and expressed about their own practices. — C.L.M.

LETTERS

SIRS: I wish to comment on the recent action by the MSMA House of Delegates on the use of stimulant drugs. Their statement that "the use of these drugs has no rational basis in the treatment of obesity" is simply incorrect. I suggest that the delegates, concerned about increasing reports in the media and increasing pressure from government bureaucracy, drew incorrect conclusions based on the commendable efforts of the drug enforcement agency as well as the Food and Drug Administration to prevent the illegal use of stimulant drugs for other reasons.

For years many physicians have found a rational use for some drugs in their efforts to assist patients in weight loss. Their use in the initiation of a treatment program is well recognized. Physicians such as myself prescribe them in small amounts and require frequent follow-up visits to ascertain their effectiveness in obtaining treatment goals. While they are certainly not indicated for long term use, they are most certainly useful to the well supervised patient under the care of a conscientious physician.

I resent the description of this type of treatment as "having no rational basis." I understand physicians in the state have been convicted and even jailed for the use of these drugs *incorrectly*. For those of us who use them sensibly and rationally, it does not help our position for the state association to adopt such inaccurate positions. I should hope that at the next annual meeting the association's position on this subject could be amended to detail those conditions in which the use of the drugs are acceptable, rather than to take the position of blanket opposition to their use.

I might make it clear that the drug which I use is Ionamin[®], not one of the amphetamines.

L. H. BRANDON, M.D.
P.O. Box 1407
Starkville, MS 39759

(Ed. Note: While this argument has some unquestioned validity, the fact that these drugs have such potential for abuse and were so often indiscriminately used prompted the House of Delegates to make this decision. Perhaps with a submitted resolution from one of the component societies, it can be reconsidered. W.M.D.)

SIRS: I am a board certified internist of more than forty years of practice. I have observed that in recent years the callous indifference of the consultant in many cases has become more prevalent.

It is the duty of the consultant to give the referring physician a prompt reply and a final opinion when necessary tests have been completed—preferably by letter, and at least by telephone. If the first consultant requires a second opinion, the referring physician should be so advised and should have a chance to approve such second consultant. On occasion another internist has been called in.

I have had three instances of failure to observe this courtesy recently. The consultant should distinguish between rendering an opinion and taking over the patient's care, unless requested to do so. Even worse, the second consultant has taken over with no authorization by the original referring physician.

Name Withheld on Request

Medico-Legal Brief

MD Sues MD
For Alleged Libel

A physician's suit for defamation against a second physician over comments made before an executive committee of a hospital was not barred by the Medical Studies Act, an Illinois appellate court ruled.

The first physician contended that at the committee meeting the second physician (1) expressed his unwillingness to continue to work with the first physician because of his dishonest and unethical practices; (2) stated that the majority of the physicians' colleagues had a very low opinion of the first physician's abilities; (3) advised that he had warned several people of the physician's shoddy practices and that one such practice had prompted his dismissal from another hospital; and (4) cited an example where the first physician's method of delivery had resulted in serious injury to an infant.

In the first physician's complaint against the second physician for compensatory and punitive damages, he claimed that the remarks were made with knowledge of their falsity or with reckless disregard of their truth or falsity. He charged that the second physician neither consulted hospital records or made any investigation to determine the accuracy of the statements. The first physician contended that he had lost patients and was not reappointed to the hospital staff because of the statements. A trial court dismissed the complaint on the ground that the remarks to the committee were absolutely privileged.

Reversing that decision, the appellate court said that the remarks enjoyed only a qualified privilege. The purpose of the Medical Studies Act was to improve the effectiveness of in-hospital peer group review by insuring that those providing information could speak freely. There was no purpose served by

allowing one physician to defame another with impunity before a hospital executive committee.

The Act did not bar the physician's suit for defamation, the court concluded. — *Matview v. Johnson*, 388 N.E.2d 795 (Ill.App.Ct., March 7, 1979; rehearing denied, April 27, 1979)

Editor's Note: The Illinois Medical Studies Act, like similar laws enacted in at least 45 states, provides a qualified privilege for physicians engaged in a variety of peer review activities. Qualified privilege protects a physician who in good faith and without malice reports his concerns about a peer to the appropriate committees of a hospital or medical staff. That this privilege does not give absolute protection is understandable. Peer review activities should be prompted by a desire to improve the quality of medical care and weed out incompetent or careless physicians, not by malice.

In *Matview*, the Illinois appellate court merely allows the first physician to attempt to prove his claims of malice. Malice has been defined by the U.S. Supreme Court as "knowledge that a defamatory statement was false, or reckless disregard of whether it was false or not."

POSTGRADUATE CALENDAR

January 25-26, 1980

ADVANCED CARDIAC LIFE SUPPORT PROVIDERS
COURSE

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology and the Medical Center Division of Continuing Health Professional Education in cooperation with the American Heart Association.

Coordinator: Thomas J. Herrin, M.D., associate professor of anesthesiology, University of Mississippi School of Medicine.

Enrollment is limited to 48 participants. Sessions will be taught by faculty certified as advanced cardiac life support instructors by the American Heart Association. All registrants must be certified in basic life support prior to the start of the course. Fee: \$100. Credit: 12 contact hours (1.2 CEU), Category I of the Physician's Recognition Award, AMA; AAFP; American College of Emergency Physicians.

February 6-7, 1980

RESPIRATORY DISTRESS IN THE NEWBORN
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Newborn Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Philip G. Rhodes, M.D., associate professor of pediatrics and chief, division of newborn medicine, University of Mississippi School of Medicine; and Gwen Bussa, R.N., M.N., C.N.M., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics and gynecology (nurse-midwifery), University of Mississippi School of Medicine.

This program will emphasize clinical recognition of respiratory distress and provide current medical management of the infant with respiratory problems. Sessions will include fetal and neonatal respiratory development and normal and pathophysiological events. Fee: \$50. Credit: 13 contact hours (1.3 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

February 7-8, 1980

RENAL UPDATE

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education in cooperation with Kidney Care, Inc., the Kidney Foundation of Mississippi, the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Coordinator: John D. Bower, M.D., professor of medicine (nephrology); Director, Artificial Kidney Unit; assistant professor of physiology and biophysics, University of Mississippi School of Medicine; and Jan Evers, assistant professor of nursing and associate nursing dean for continuing education, University of Mississippi School of Nursing.

This is a joint program for physicians, registered nurses, social workers and dietitians. Segments for physicians will center on developments in nephrology and the major role played by the family physician in the management of renal disease. The program is directed specifically toward those nephrologic problems encountered by the family physician. Fee: \$50. Credit: 13 contact

POSTGRADUATE / Continued

hours (1.3 CEU), Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

February 9-10, 1980

CONTINUOUS AMBULATORY PERITONEAL DIALYSIS WORKSHOP

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine Division of Nephrology, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education in cooperation with Kidney Care, Inc., and Travenol Laboratories.

Coordinator: Jack Rubin, M.D., assistant professor of medicine (nephrology), University of Mississippi School of Nursing.

This program will address major problems physicians, nurses, dietitians and social workers might encounter in setting up a CAPD program. Sessions will include problems of peritonitis, patient selection, nutritional status, fluid control and dialysate protein losses. Fee: \$50. Credit: 8.5 credit hours (.85 CEU) Category I of the Physician's Recognition Award, AMA.

FUTURE CALENDAR

March 13-15, 1980

SURGICAL FORUM VII

Holiday Inn Downtown, Jackson

March 27-28, 1980

NEUROLOGY

Holiday Inn Medical Center, Jackson

April 3-4, 1980

INFECTION IN THE NEWBORN

University Medical Center, Jackson

PRACTICE MANAGEMENT MAILBOX

MSMA receives numerous questions from members concerning various aspects of good practice management. This month JOURNAL MSMA begins a series of articles based on practice management inquiries. If you have a particular question you would like covered in a future article, write MSMA Practice Management Mailbox, P. O. Box 5229, Jackson, MS 39216.

Consent Requirements in Treatment of Minors

A question frequently posed by members of the association concerns consent requirements in the treatment of minors. Mississippi has specific statutes dealing with medical consents which are found in Section 41-41-1, et seq. of the Mississippi Code of 1972, annotated, as amended.

As most physicians are aware, no parental consent is necessary when treating a minor for venereal disease. Another specific treatment without parental consent authorized by statute is the treatment of minors, 15 years of age and older, for mental and/or emotional problems caused by or related to drugs or alcohol. In drug and alcohol related cases, the physician may (but is not required to) inform the parent or guardian of the minor of the treatment given, over

the express refusal of the minor. The third specific exemption for minors is that persons 17 years old and older may donate blood without parental consent.

In addition to these specific exemptions, there are additional categories of minors who may consent for themselves. First, any minor who is married is viewed by the law as being emancipated and thus is free to give consent for treatment. Also, any minor who has become emancipated by any other means, such as a court decree removing disabilities of minority, can consent for himself. Any female, regardless of her age or marital status, may consent for herself when such consent is given in connection with pregnancy or childbirth.

There is one other broad category of minors specifically mentioned who are allowed to consent for themselves. Section 41-41-3 (h) provides that "Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures," may consent for himself. This section puts a burden on the physician by causing him to make a judgment decision as to the minor's intelligence. MSMA would advise physicians to rely on this statutory provision only as a last resort. In other words, if it is at all possible to obtain the consent of an adult when treating a minor, do so. — B.C.M.

MEDICAL ORGANIZATION

MSMA Board Holds Fall Meeting

MSMA's Board of Trustees held its regular fall meeting in Hattiesburg on Dec. 13-14 and participated with the South Mississippi Medical Society in recognizing MSMA president Dr. Gerald P. Gable.

Primary business coming before the Board was the association's 1980 budget as recommended by the Council on Budget and Finance. The Board approved a \$909,582 budget to include expected AMA dues transmittals amounting to \$300,000.

The Board also considered other reports and recommendations from councils and committees of the association. These included reports on the association's 1980 legislative program and plans for the 112th Annual Session.

The administrator of the association's group insurance programs, Thomas A. Yates, reviewed the current status and future plans of the program. Mr. Yates announced a new cancer insurance policy which will soon be made available to the membership. He also discussed improvements in other programs to include higher excess major medical benefits, lower life insurance rates and higher benefits, continuation of "senior" disability coverage, and a waiver of premium addition to the Overhead Expense Plan.

The Board reviewed reports from MMPAC and MSMA's Delegates to the AMA and heard plans for a public information program sponsored by the association in cooperation with the Burroughs-Wellcome Company. A new Committee on Federal/State Health Programs was organized and a review of the association's building program and needs was authorized.

The Board also acted to accept a proposal from AVIS Rent-A-Car for a 25% membership discount and endorsed the Mississippi Chapter, American Academy of Pediatrics' program stressing seat belts for children.

Association officers at the Board meeting were: Drs. Gerald P. Gable, Hattiesburg, president; J. Elmer Nix, Jackson, secretary-treasurer; R. Faser Triplett, Jackson, speaker, House of Delegates;

Lamar Weems, Jackson, AMA delegate. Board of Trustees members included: Drs. Arthur A. Derrick, Jr., Durant, chairman; Sidney O. Graves, Natchez, vice chairman; Paul H. Moore, Pascagoula, secretary; Joe S. Covington, Meridian; W. Joseph Burnett, Oxford; Ellis M. Moffitt, Jackson; William C. Gates, Columbus; Whitman B. Johnson, Clarksdale; and W. Boyce White, Laurel.

Pediatricians Conduct Annual Meeting



Dr. Larry Hebert of Baton Rouge, center, addressed the annual meeting of the Mississippi Chapter of the American Academy of Pediatrics, held in Jackson in November. Dr. Hebert, medical director of Louisiana Child Protection Programs and chief of pediatrics at Earl K. Long Memorial Hospital, discussed the long-term effects of child abuse. Chapter Chairman Dr. William F. Sistrunk of Jackson, left, and Alternate Chairman Dr. Robert H. Thompson of Jackson conducted the sessions for the annual meeting, which celebrated the twenty-fifth anniversary of the founding of the Department of Pediatrics at UMC.

112th Annual Session
April 27-May 1, 1980
Plan to Attend

Dr. Wilkins Delivers Batson Memorial Lecture



Dr. Jeanette Wilkins of the University of Southern California Medical Center delivered the Claud L. Batson Memorial Lecture during the annual meeting of the Mississippi Chapter, American Academy of Pediatrics. She is pictured with Dr. Blair Batson, UMC pediatrics department chairman. Dr. Wilkins, a Mississippi native, spoke on infectious disease and her work as director of the Hastings Foundation Infectious Disease Research Laboratory.

DOC Uses Counter Advertising For Prevention

"We're the Good Health People"

At a time when the "health care industry" is responding to daily charges of causing the high cost of medical care, a young Miami physician is leading a grassroots effort to "place the blame squarely where it belongs — on the industries which promote bad health."

During his "Superhealth '79" program, Dr. Alan Blum told some 600 public health workers attending the Mississippi Public Health Association convention in Jackson that the number one preventable cause of illness (and high medical costs) is cigarette smoking. He maintained that the traditional approach to patient education about the dangers of smoking has simply not worked. The reason, he said, is the enormous success of cigarette advertising.

Does it pay to advertise? Dr. Blum points out that more women and youth are smoking now than ever before, and he notes the discrepancy in budgets for cigarette advertising (\$2 million per day by the tobacco industry) and smoking awareness programs (\$1 million per year by the federal government). He maintains that the tobacco industry has "sold" us an epidemic of costly, devastating diseases. "You've

Come a Long Way, Baby," declares the cigarette ad directed to women smokers. Yes, agrees Dr. Blum, women have come a long way — to a 500% increase in lung cancer during the last 30 years and a heart attack rate which approaches that of men.

Medical science itself has even been used to promote smoking, he said, recalling the advertisements some years ago which proclaimed, "More Doctors Smoke Camels Than Any Other Cigarette," "Many Leading Nose and Throat Specialists Suggest Change to Philip Morris," and "L & M, Just What the Doctor Ordered." Today's advertisements appeal to the desire for physical attractiveness and social success.

It was the realization that the nation's young people were "getting the message" of the bad health promoters rather than the message of preventive medicine that prompted Dr. Blum and several other resident physicians to form in 1977 a non-profit organization called DOC, an acronym for "Doctors Ought to Care." He and his associate, Dr. Rick Richards of Georgia, explained the "ought" is not intended to imply that physicians don't care but rather to emphasize that they are the ones who do care.

The DOC organization, which now numbers more than 500 health professionals across the country, has declared war on the devastating effects of smoking, alcohol and drug abuse, teenage pregnancy and poor nutrition. Their weapons are clever, selectively purchased counter-advertisements directed toward a group which has been most receptive to (and a prime target of) advertising — adolescents. DOC also uses posters, promotional T-shirts, speakers bureaus, radio shows and newspaper columns to deliver the preventive medicine message. Their tactics are humor, good sense and genuine concern (ads are signed, "With Love, DOC."). Their aim is to stop bad health habits before they start.

If DOC is successful, Dr. Blum said in an interview with JOURNAL MSMA, the result will be a whole new generation of healthy young people who will make intelligent, informed, independent decisions about the killer habits, rather than succumb to the insidious message of advertising. The impact on the cost of medical care will be enormous, and the declining image of physicians will be enhanced, as well. "We're not just anti-smoking," he said, "we're anti-emphysema, anti-lung cancer and anti-heart disease."

"We should use the same ingenuity to promote good health as they have used to sell bad health," he concluded, in response to a comment on DOC's imaginative approach.

Health Groups Endorse State DOC Chapter

Several health organizations, including the Mississippi Academy of Family Physicians and the State Board of Health, have endorsed the formation of a DOC ("Doctors Ought to Care") chapter in the state. Tom Houston, M.D., chief resident in the Department of Family Medicine at the University Medical Center, will head the organization effort.

"We are all faced with the dilemma of educating our patients in positive attitudes toward their own health, and most of us do not have a very good batting average. The problems of smoking and alcohol abuse contribute to over 500,000 deaths annually in the United States," said Dr. Houston, describing the difficulties associated with patient education.

As is done on a national level, the local chapter will utilize various techniques in an aggressive patient education campaign. Counter advertising, posters, radio and television messages and newspaper columns will be potential avenues of education.

Specific steps can be taken immediately by physicians, according to DOC spokesmen. Physicians are urged to examine reading material in their waiting rooms and substitute publications which do not accept cigarette ads for those popular magazines such as *Time*, *Newsweek*, and *Sports Illustrated*, which contain many pages of cigarette advertisements. Ironically, Dr. Houston notes, those same magazines often carry articles complaining about the high cost of medical care.

For more information about DOC, write to Dr. Houston at UMC, 2500 North State St., Jackson, MS 39216.

NEW MEMBERS

DAWKINS, WALTER E., II, Natchez. Born Fayette, MS, Nov. 1, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Boston Naval Hospital, Chelsea, MA, one year; family practice residency NRMCC, Charleston, SC 1973-75; elected by Homochitto Valley Medical Center.

DECoux, ROBERT E., JR., McComb. Born McComb, MS, Oct. 22, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, same, one year; medicine residency, same, 1975-77; gastroenterology residency, same,

1977-79; elected by South Central Medical Society.

IRBY, HENRY E., Jackson. Born Lena, MS, March 10, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1962; interned Mississippi Baptist Hospital, Jackson, one year; elected by Central Medical Society.

LILLARD, PATRICK LYNN, Jackson. Born Oct. 19, 1940; M.D., University of Cincinnati College of Medicine, Cincinnati, OH, 1966; interned University of Southern California, Los Angeles County Medical Center, one year; family practice residency, Santa Monica Hospital, Santa Monica, CA, 1970-71; general surgery residency, White Memorial Medical Center, Los Angeles, CA 1971-72; neurosurgery residency, University of Mississippi Medical Center, 1972-77; elected by Central Medical Society.

MONTGOMERY, CHARLES W., Tupelo. Born Memphis, TN, Sept. 25, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, same, one year; medicine residency, same, 1975-77; fellowship hematology and oncology, same, 1977-79; elected by Northeast Mississippi Medical Society.

RUBIN, JACK, Jackson. Born Montreal, Quebec, Canada, Nov. 19, 1946; M.D., University of Saskatchewan Medical School, Canada, 1971; interned Toronto General Hospital, 1971-72; medicine residency, same, 1972-77; nephrology residency, University of Missouri Medical Center, Columbia, MO 1978-79; elected by Central Medical Society.

SHANDS, THOMAS ANDREW, New Albany. Born New Albany, MS, March 25, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; medicine residency, same, 1977-79; elected by Northeast Medical Society.

SHEEN, SIDNEY MICHAEL, McComb. Born Leeds, England, May 30, 1934; M.D., University Leeds Medical school, Leeds, England, 1961; interned York County Hospital, York, England, one year; anesthesiology residency, Burnet Lanes, England, 1962; anesthesiology residency, York County Hospital, 1968-69; elected by South Central Medical Society.

SMITH, ROBERT E., Jackson. Born Akron, OH, Nov. 17, 1922; M.D., University School of Medicine, Philadelphia, PA, 1948; interned Akron City Hospital, Akron, OH, 1948-49; elected by Central Medical Society.

NEW MEMBERS / Continued

VELEZ, HERNANDO, Collins. Born Montenegro, Colombia, South America, Aug. 9, 1939; M.D., National University School of Medicine, Bogota, Colombia, 1965; interned John Hospital, Detroit, MI, 1971-72; radiology residency, University Valle, Colombia 1969-71; radiology residency, Harper Hospital, Detroit Medical Center, MI, 1972-74; elected by South Mississippi Medical Society.

VISE, RICHARD MARTIN, Meridian. Born Meridian, MS, May 31, 1948; M.D., University of Mississippi School of Medicine, Jackson, MS, 1974; interned Ochsner Foundation, New Orleans, LA, 1974-75; urology residency, University Medical Center, Jackson, MS, 1975-79; elected by East Mississippi Medical Society.

PERSONALS

JOHN E. ALDRIDGE has associated with JOEL L. ALVIS and W. H. MERRELL, JR. of 500-C E. Woodrow Wilson, Jackson, for the practice of urology.

W. R. GILLIS of Jackson and UMC presented a family medicine workshop in San Antonio, TX, during November.

FRANK GRUICH of Biloxi was recently inducted into the Gulf Coast Junior College Alumni Hall of Fame. He had previously been awarded the Sam Owen Award for distinguished service to the college.

SAMMY HAMWAY of Clarksdale spoke on "Nursing Care of the Urological Patient" at the North Delta District Nurses Association meeting at the Northwest Mississippi Regional Medical Center.

JAMES D. HARDY of UMC was guest speaker at a meeting of the Kansas Chapter of the American College of Surgeons.

HARPER K. HELLEMS of UMC was visiting professor of medicine at Wayne State University and Detroit General Hospital in Michigan.

THOMAS HERRIN of UMC presented a paper at the November meeting of the Southern Medical Association.

J. EDWARD HILL, JOHN M. ESTESS, and WILLIAM H. SPRAGINS of Hollandale Clinic announce the association of DAVID B. KEDDY for the practice of family medicine at the Greenville Branch Clinic.

ROBERT D. HOLBERT and FREDERICK D. ROGOFF of Pascagoula announce the opening of their office for the treatment of high blood pressure and diseases of the kidney.

JAMES L. HUGHES was among UMC faculty members who presented papers at the Southern Medical Association meeting in Las Vegas.

HERBERT LANGFORD of UMC chaired a session of a recent meeting of the American Heart Association and was speaker for a Kraft Nutrition Seminar in Chicago.

WILLIAM E. LOTTERHOS announces the opening of his office for family practice at 385 Medical Drive in Jackson.

CHARLES MARASCALCO of Vicksburg spoke at a recent meeting of the Vicksburg Rotary Club.

J. DANIEL MITCHELL of Jackson announces the association of BILLY N. WATKINS in family practice.

SCOTT K. ROSS of Canada will associate with D.M. SEGREST of Port Gibson in general medical practice.

GEORGE V. SMITH of UMC presented a paper at Southern Medical Association's Las Vegas meeting in November.

J. TATE THIGPEN of Jackson was recently appointed to the American Red Cross National Field Office Advisory Council.

Auxiliary Workshop Stresses Total Fitness



Special guest at MSMA Auxiliary's fall workshop was Mrs. Mylie Durham, second from right, Southern Regional Health Projects chairman for the AMA Auxiliary. Discussing promotion of the national "Shape Up for Life" campaign were MSMA Auxiliary officers, from left, Mrs. Curtis Roberts of Brandon, Mrs. Jim C. Barnett of Brookhaven and Mrs. James B. Martin of Ocean Springs. (Photo by Jeff McAdory of the Jackson Daily News.)

Dr. Taylor Heads Tulane Medical Alumni

Dr. C. D. Taylor of Pass Christian has been elected president of the Tulane Medical Alumni Association.

A New Orleans native, Dr. Taylor attended Louisiana State University and received his M.D. degree from Tulane. Following internship at St. Luke's Hospital in Chicago and residency at Lakeshore Hospital in New Orleans, he established his family medicine practice in Pass Christian. Dr. Taylor is a member of Coast Counties Medical Society and Southern Medical Association.

He has been chairman of MSMA's Board of Trustees, speaker of the House of Delegates, and delegate to AMA.



Hospitals Report No Nuclear Crisis — Yet

Although the recent closing of two nuclear waste disposal sites created no immediate difficulties for Mississippi hospitals, certain other problems could develop which might affect patient care.

Nuclear medicine spokesmen at several state hospitals expressed concern that their supplies of radiopharmaceuticals could be cut off. This action would deprive many patients of necessary medical tests and treatment, they remarked.

The Radiological Health Department of the Mississippi State Board of Health reports that all state hospitals have adequate storage for the short-lived radioactive waste resulting from the diagnostic and therapeutic application of nuclear medicine. However, manufacturers of nuclear medicine equipment and supplies could soon begin to feel the effects of the shortage of dumping sites. One nuclear medicine technician, explaining that his hospital uses one Technetium generator each week, noted the potential problem that could result if the manufacturer can no longer take back the spent generators for disposal.

Research institutions across the nation are already being affected, according to a statement from the Society of Nuclear Medicine, but a spokesman for a research department at University Medical Center

stated that at the present time UMC has no urgent problems. A commercial facility still accepts UMC's radioactive liquid waste.

Mississippi officials are monitoring the situation in the state and will be prepared to assist hospitals which anticipate problems, following procedures outlined in the contingency plan developed by the Federal Emergency Management Agency immediately following the closing of the Nevada disposal site.

The American Medical Association, testifying with other concerned organizations before the House Subcommittee on Energy Research and Production, emphasized the importance of a long-term solution to the disposal problem. Leonard H. Freeman, M.D., remarked, "Countless lives have been saved as a result of the valuable contribution that the use of radiopharmaceuticals have made in improving the detection and treatment of disease. Radioisotopes have been especially helpful in the early detection and the effective treatment of various forms of cancer. Of equal significance has been the contribution that radiopharmaceuticals have made in medical research."

"Inability to dispose of low-level medical nuclear waste products threatens to make these lifesaving diagnostic and therapeutic procedures unavailable to thousands of persons who desperately need these services," Dr. Freeman concluded.

Dr. Jaquith Retires

Dr. W. L. Jaquith retired Dec. 31 after 32 years of service as director of Mississippi State Hospital at Whitfield. During his tenure he became known as the father of Mississippi's mental health program.

The Vicksburg native was appointed to head the state's mental hospital in 1947, becoming the only physician for 800 patients. He described conditions at the hospital at that time as "appalling." He believed public and legislative apathy to be responsible for the terrible state of the buildings, the lack of sanitation, and inadequate medical care and nutrition, and he set about to overcome years of neglect.

Rejecting offers to take over larger institutions in other states, Dr. Jaquith began to bring before the legislature the needs of that state's mentally ill and retarded patients. He succeeded in his efforts to have the hospital's board removed from politics and to mobilize the public and legislators into a reform force.

Resulting from his efforts have been a \$25 million renovation project at the Whitfield facility and the

DR. JAQUITH RETIRES / Continued

formation in 1974 of the new State Department of Mental Health and Retardation. In 1975 he accepted the appointment to head the new department which oversees two mental hospitals, Ellisville State School and four retardation centers.

Dr. Jaquith, recipient of the 1979 MSMA-Robins Award for Community Service, is a long-time member of MSMA and has served as chairman of the Committee on Aging and the Committee on Mental Health. He is a past president of Central Medical Society. A member of numerous specialty organizations, Dr. Jaquith has also served as consultant to the Jackson Council on Alcoholism and as a member of the Professional Advisory Board of the Mississippi Mental Health Association. For many years "Dr. Jake," as he has become known to many Mississippians, has been an active speaker before student and civic groups throughout the state on the subject of drug abuse.

Mississippi Medicine— 1979 In Review

A review of medical events in Mississippi during 1979 shows that there were significant areas of improvement. The state achieved a 98.9% immunization rate among school children, the result of legislative action and vigorous efforts by health professionals, volunteers, school personnel and parents.

There was also reported a drop in infant mortality. Efforts to improve access to care for high risk newborns by way of MSMA's proposed regionalization program and UMC's new perinatal hotlines are expected to produce further improvement in this area.

On the negative side, however, increases in new tuberculosis cases and in syphilis and gonorrhea were reported. Mississippi has the highest incidence of new cases of tuberculosis in the continental United States, according to the State Board of Health.

Hypertension also continues to be a serious problem in Mississippi. The State Board of Health this year undertook an expanded program to improve detection and treatment. A significant development in hypertension research occurred in December, when results of a five-year nationwide study headed by Dr. Herbert Langford of UMC were reported. The study showed that aggressive treatment of mild high blood pressure reduced the number of deaths from heart attack and stroke.

Stroke victims, their families and physicians, as well as patients at risk of stroke, gained access to additional information and help with the inauguration during the summer of a new stroke service at Mississippi Baptist Medical Center. This program joined an existing service at University Medical Center in an international study of stroke prevention and treatment, with special emphasis on the brain/artery bypass. Strokes continue to be the third leading cause of death in Mississippi, according to public health statistics.

In 1979 emergency medical care services were extended to more Mississippi citizens through the regionalization of such services under the direction of the EMS division of the State Board of Health. It is believed that further regionalization will reduce the number of accidental deaths. The state's accidental death rate (65.7 per 100,000) remains above the national average (47.7 per 100,000). Motor vehicle accidents account for 33.8 of those, compared with the national average of 24.8.


Early in the year, the services of the state's poison control center became available to physicians throughout the state by way of 24-hour telephone access, providing immediate consultation with a full complement of medical and scientific specialists. The Center also initiated a special public information effort aimed at reducing the number of accidental poisonings in children. (As many as 80% of all accidental poisonings occur in children under five.)

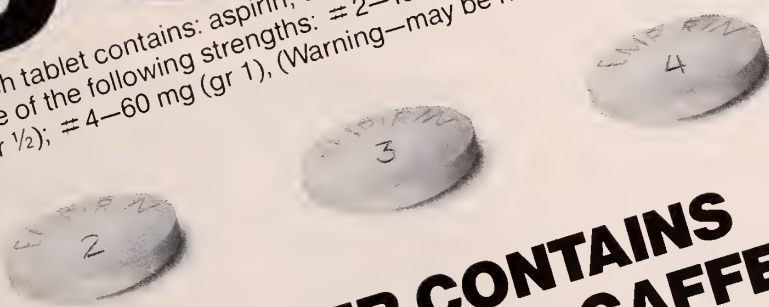
There has also been an increase in the size of Mississippi's physician population. Statistical information reported in 1979 indicates that between 1975 and 1978 the state had a net increase of 317 physicians.

Besides these specific measures aimed at preventing some of the major causes of death and disability in Mississippi and improving access to medical care, individual physicians and health groups placed renewed emphasis on general preventive medicine. As was done throughout the nation, patients were told of the importance of good nutrition, proper exercise and the avoidance of unhealthy habits.

If early education is a key to successful preventive medicine efforts, as many health professionals believe, and if a health education program in schools is instituted as recommended by MSMA, similar reviews of medical advances in Mississippi in future years may show significant progress in these areas of medical need.

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RECOLLECTIONS

The January 1960 issue of JOURNAL MSMA recorded these items:

—The association announced plans developed by the Council on Medical Service for improved care of the aging and the indigent. The proposals, based on community and state action without federal involvement, called for cooperation among many state health organizations.

—The 86th Congress was due to reconvene, and was expected to consider the much-debated Forand legislation calling for a program of national health insurance.

—Dr. H. H. McClanahan of Columbus, chairman of MSMA's Board of Trustees, was named delegate to the U. S. Pharmacopoeial Convention, and Dr. Raymond F. Grenfell of Jackson was named alternate.

—*Biopsy Manual*, newly published by UMC physicians James D. Hardy, James C. Griffin, Jr., and Jorge A. Rodriguez, was reviewed as a "well presented, timely and well illustrated manual."

—Scientific papers included "Hypothyroidism and Myxedema," by Dr. L. T. Carl of Jackson; "Thyroid Carcinoma: Diagnosis and Management," by Dr. George H. Martin of Vicksburg; "Review of Methods of Diagnosis and Treatment of Female Sterility," by Dr. George J. Nassar, of Greenwood; and "Staphylococcal Pseudomembranous Enterocolitis," by Drs. Kenneth M. Heard, W. C. Shands and George E. Twente of Jackson.

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The Mississippi State Medical Association offers this placement service free of charge to Mississippi hospitals or clinics seeking physicians, and to physicians seeking to relocate in the state. Display advertisements will be charged at regular rates. Out-of-state clinics advertising for physicians will be listed in the classified department at regular classified rates.

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

FAMILY PRACTITIONER or general practitioner with surgery interest. Free office space. Moving expenses paid. Modern 36-bed hospital with 60-bed extended care facility. Contact: Nick Wilson, Administrator, Quitman County Hospital, Box 330, Marks, MS 38646. Call collect (601) 326-8031.

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PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

ASSOCIATES or physicians interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

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PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

GENERAL SURGEON (Board Certified) with wide experience. Interested in relocating to MS. Native of Louisiana; formerly practiced there. C-V on request. Contact: Marvin M. Ettinger, M.D., 827 Puma Canyon Lane, Glendale, CA 91740.

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Feb. 6, 1980

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Index to Advertisers

Burroughs Wellcome Co.	14D, 19	Parke, Davis & Co.	16
Canton Exchange Bank	15	Premier Printing	15
Citizens Bank	6	Riverside Hospital	8
Coca-Cola	7	Roche Laboratories	second, third and fourth covers
Harreld Chevrolet-Oldsmobile	19	Smith Kline and French	14A
Eli Lilly and Co.	6A	The Upjohn Co.	14B, 14C, 14D
Merck Sharp & Dohme	6B, 6C and 6D	Wyeth Laboratories	10A, 10B, 10C, 10D
Miss. Medical Fraternal and Educational Society	12	Thomas Yates and Co.	20
Mississippi Stationery Co.	7		

IN CONCLUSION

The FDA has granted permission to Nuclear Medical Systems, Inc. to market two radio-immunoassay blood test kits which have been supplied to physicians and laboratories on a provisional basis since October. The "PAP-Chek" test kit is said to detect prostate cancer before traditional symptoms appear by revealing the presence of the "marker" Prostatic Acid Phosphatase (PAP), which is absent in healthy humans. The "Cardio-Chek" test kit is said to detect and diagnose the severity of heart attacks within 15 minutes.

The success of the antismoking lobby was credited in a recent article with downward trends in cigarette sales suffered by four major manufacturers in 1979, the fourth consecutive year in which the volume growth rate has declined. Industry spokesmen acknowledged that potential smokers are being scared away and that others are switching to low tar brands. Corporate strategy, says one executive, is now geared to taking away from competitors rather than expanding the total market. The industry has introduced 55 new brands in the last three years.

The Environmental Protection Agency is concerned that some homeowners, in sealing up their dwellings in energy conservation measures, may also be trapping harmful air pollutants inside. Nitrogen oxides and carbon monoxide, produced by gas appliances and cigarettes, may have hazardous effects; but the primary concern is with formaldehyde (used in foam insulation and other building products) and radon gas, which could cause many new cases of lung cancer each year if ventilation is significantly reduced, said an EPA spokesman.

Nationwide, less than five percent of high-risk persons have received the pneumococcal pneumonia vaccine in the 20 months since it has been made available. A news item reports that in Massachusetts, however, some 130,000 of the state's 1.3 million citizens at high risk - the chronically ill and those 60 years or older - have received the vaccine. Pneumonia from all causes continues to be the nation's fifth largest killer, and pneumococcal pneumonia accounts for about 54,000 deaths each year, according to a recent U.S. Surgeon General's report.

Disabling angina pectoris that does not respond to medical treatment is the leading indication for performing coronary bypass surgery, according to the AMA's Council on Scientific Affairs in a report in the December 14 JAMA. Other indications for the surgery, as well as non-indications, were also identified. With the guidance of a team of heart specialists and heart surgeons, the Council also listed a number of conditions in which the evidence is not yet conclusive. Future reports will focus on such issues as saccharin, community mental health centers and diabetes.



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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

2EAST 103RD ST
NEW YORK N.Y.

Her next attack of cystitis may require the BactrimTM 3-system counterattack



Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has no significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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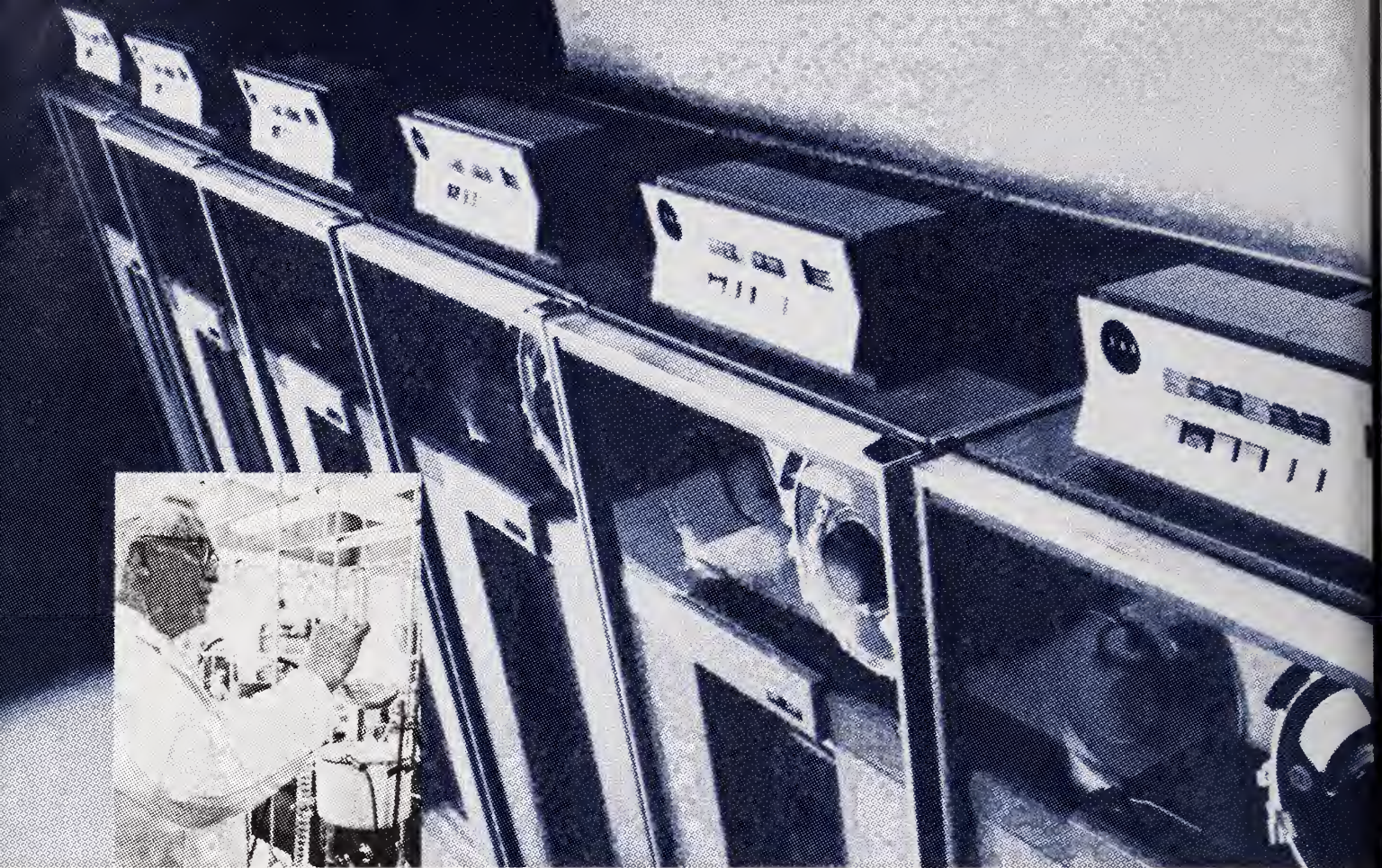
Contents:

Nuclear Imaging of
the Heart

Improved Thyroid
Uptakes and
Scans with Iodine-123

National Health
Service Corps:
Boon or Boondoggle?

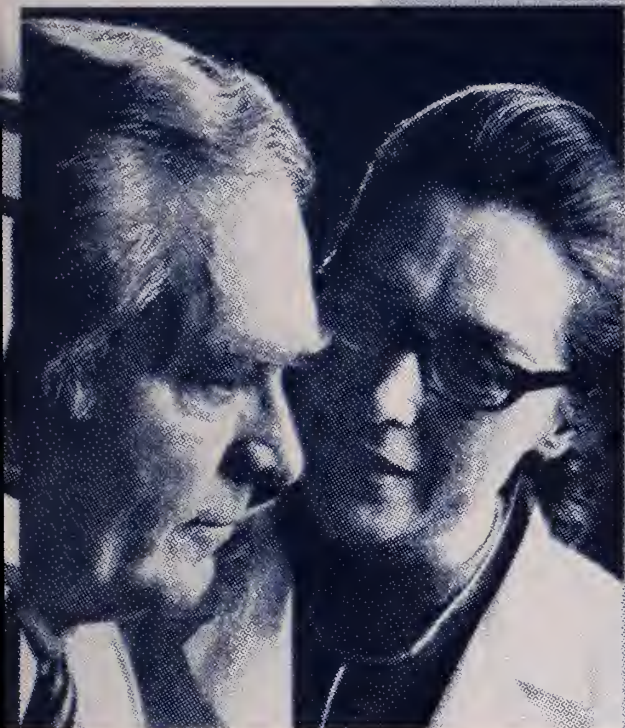




proven antianxiety

Highly specific calming action
virtually free of unwanted
side effects: this was the remarkable
clinical promise of Librium (chlordiazepoxide HCl).
And today this promise continues to be
fulfilled in a wide variety of patients
you see every day.

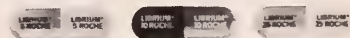




The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium[®]
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

***synonymous
with relief
of anxiety***

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium[®] 5mg, 10mg, 25mg capsules *chlordiazepoxide HCl/Roche*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Products Inc.
Manati, Puerto Rico 00701

Physician Fees Remain Below CPI

For the fourth consecutive month, inflation in the general economy outpaced physician fee increases in November of last year. The all-items component and the all-services component of the Consumer Price Index rose 0.9% and 1.1%, respectively, while physicians' fees were rising 0.4%.

During November, the dental services component went up 1.0% and hospital room charges rose 1.3%. The total medical care services index increased 0.9%, the same as all-items index.

ADA Joins JCAH

The American Dental Association has accepted an invitation from the Joint Commission on Accreditation of Hospitals to become a corporate member. The ADA will have one vote on the JCAH Board of Commissioners.

"The representation of dentistry on JCAH's board is compatible with our long-range goals and will strengthen the decision-making capabilities of our organization," said JCAH President John E. Afeldt, M.D. Others on the board are the AMA (seven votes), the American Hospital Association (seven votes), the American College of Surgeons (three votes), and the American College of Physicians (three votes).

Rural Health Conference Offers CME Courses

Seven continuing medical education courses placing emphasis on the needs of the rural practitioner will be offered in conjunction with the American Medical Association's 33rd National Conference on Rural Health, scheduled for April 17-18 at the Sheraton Boston in Boston, MA.

The courses, which meet the criteria for Category 1 accreditation on an hour for hour basis for the Physician Recognition Award of the AMA, will discuss these topics: common poisoning emergencies, sports medicine in rural schools, plastic wound closure techniques for the primary care physician, nutritional assessment and management in rural areas, agricultural health problems, primary management of severe head trauma and microsurgery techniques in hand amputation.

For more information, write to the Department of Community Health Systems, American Medical Association, 535 North Dearborn St., Chicago, IL 60610.

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CONTENTS

ORIGINAL PAPERS

- Nuclear Imaging of the Heart **23** OTTIS G. BALL, M.D.
Jackson, MS
- Radiologic Seminar **27** FRED G. EMRICK, M.D. and
CXCIX: Improved Thyroid W. MEL FLOWERS, M.D.
Uptakes and Scans With Jackson, MS
Iodine-123

SPECIAL ARTICLE

- National Health Service **29** PATSY SILVER
Corps: Boon or
Boondoggle?

EDITORIALS

- Federal Trade Commission **33** MYRON W. LOCKEY, M.D.
Jackson, MS
- HEW Will Seek Another **33** CHARLES L. MATHEWS
Second Opinion
- No Advertising for Doctors **34** Reprinted from the
Kosciusko *Star-Herald*

THIS MONTH

- The President Speaking **32** Let's Plan for a
Great Convention
- Practice Management **36** Accurate Medical Records
Mailbox
- Medical Organization **37** MSMA Plans Activities as 1980
Legislature Convenes
- Recollections **44** From the February 1960
JOURNAL MSMA

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Second Annual Ophthalmology Course Is Presented



Dr. David L. Guyton, left, assistant professor of ophthalmology at Johns Hopkins University School of Medicine in Baltimore, presented the second annual ophthalmology course at the University of Mississippi Medical Center in December. With him is Dr. Raul Valenzuela, professor of surgery (ophthalmology). In two days of lectures, Dr. Guyton covered physiological optics, refraction, and strabismus. The course was open to practicing physicians, and UMC students and residents. Made possible by a gift from the Jackson Central Lions Club, the offering was sponsored by the UMC Department of Surgery Division of Ophthalmology and the Division of Continuing Health Professional Education.

Guardian Society Plans Continuing Education Day

The Hon. J. P. Coleman, chief justice of the fifth circuit court district, will address University of Mississippi Medical Center alumni at a dinner April 19 in Jackson.

The dinner at the Holiday Inn Downtown will climax "Continuing Education Day" at the Medical Center. The event is sponsored by the Guardian Society of the Medical Alumni Chapter of the University of Mississippi Alumni Association. Alumni from the Schools of Medicine, Nursing, Health Related Professions and Dentistry plan seminars in their disciplines during the day.

Judge Coleman will speak at a dinner during which the Guardian Society will honor 13 Mississippians who were in leadership positions during the Medical Center's formative years.

Dr. Wallace Conerly, chairman of the Guardian Society committee coordinating the event, says the Medical Center will co-sponsor CE Day for continuing education accreditation purposes.

"As plans develop, alumni of all schools will receive detailed information about the program," he said.

QuinammTM

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication. Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

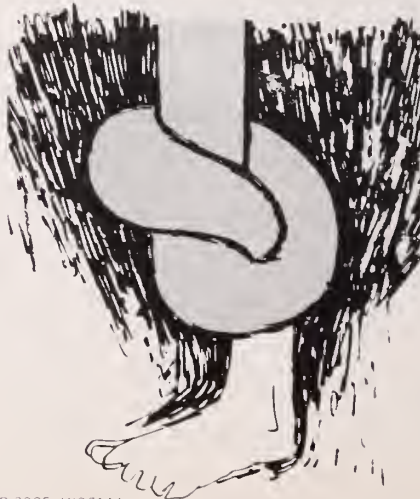
U.S. Patent 2,985,558

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each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

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Alpha Stimulation

Central Control of
Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres

The Alpha Advantage:

It's for all kinds of hypertensives

- Unlike beta blockers, Catapres® has no contraindications.
- Catapres can be useful even in these patients with:

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido:
2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

* Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new
0.3 mg tablets**

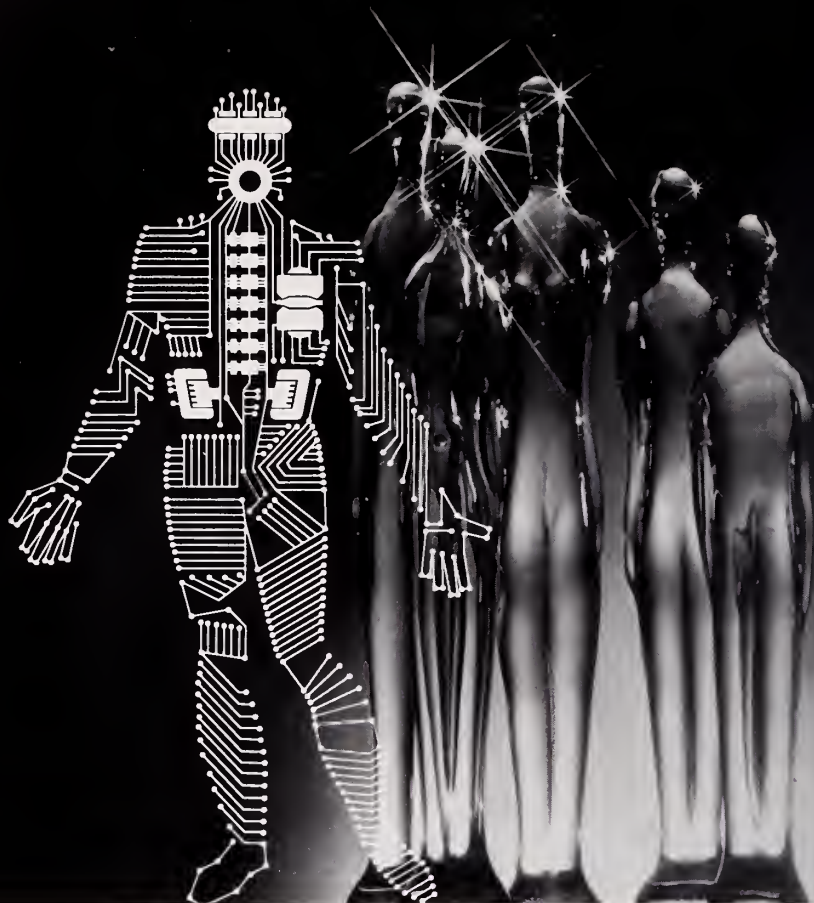
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Catapres
(clonidine HCl)
Hypertension





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Tablets of 0.1, 0.2, 0.3 mg
Catapres
(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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UMC Announces New Faculty Members

Two associate professors are among the nine new faculty members named at the University of Mississippi Medical Center this month.

Coming to the Medical Center as associate professors are Dr. John P. Kapp in neurosurgery, and Dr. Ronald P. Krueger in surgery (urology). Named assistant professors of physiology and biophysics are Dr. Terry M. Dwyer and Dr. Marcy F. Petrini.

Instructors joining School of Medicine faculties are Dr. David M. Ferriss and Kay Mashburn, family medicine; Martha Pollard Baird, obstetrics and gynecology (nurse-midwifery); Evaline T. Nicolls, obstetrics and gynecology; and Dr. Venkateshia Sathyanarayana, clinical laboratory sciences.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Kapp, attending neurosurgeon at Gulf Coast Community Hospital in Panama City, Florida, since 1977, earned the B.S., M.D. and Ph.D. degrees at Duke University. He was chairman of the scientific program committee for supplementary scientific sessions for the Congress of Neurological Surgeons in 1975.

Dr. Krueger, assistant professor of urologic surgery at Duke since 1975, also earned the M.D. at Duke. He is former chief of the division of pediatric nephrology at Duke University Medical Center.

A physiology research associate at the University of Washington since 1978, Dr. Dwyer earned the B.S. degree at Fordham University and the M.D. and Ph.D. degrees at the University of Rochester.

Surgical Congress Sets Annual Assembly

The Southeastern Surgical Congress will hold its 48th Annual Assembly April 28-30 at the Marriott Hotel in Atlanta, GA. The Assembly offers 28.5 hours of Category 1 credit.

A postgraduate course, "Prevention, Detection and Management of Complications Following Abdominal Surgery," providing eight hours of Category 1 credit, will be presented April 27.

For information about the Assembly or the concurrent nurses' program, write to: Southeastern Surgical Congress, 315 Boulevard, NE, Suite 500, Atlanta, GA 30312.

UMC Establishes New Hand Surgery Service

A new hand surgery service has been established at the University of Mississippi Medical Center for the comprehensive care of patients with injuries to and illnesses which affect the hand and forearm.

The service is administered jointly by the Department of Surgery's Division of Orthopedics and the Division of Plastic Surgery. Physicians who wish to refer patients to the service may call orthopedics at 987-4557 or plastic surgery at 987-5566.

New Orleans Graduate Medical Assembly Is Scheduled

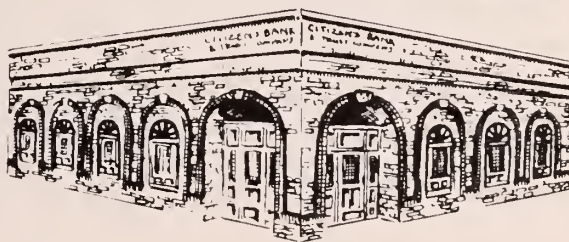
The 43rd Annual New Orleans Graduate Medical Assembly will be held Feb. 27-March 2 at the Fairmont Hotel in New Orleans.

Registration fee is \$200 for non-member physicians, \$100 for registered nurses. Complimentary registration is provided for students, residents, interns and in-training fellows.

For more information call (504) 525-9930 or write for a copy of the program. The address is Room 1538 Tulane Medical Center, 1430 Tulane Ave., New Orleans, LA 70112.

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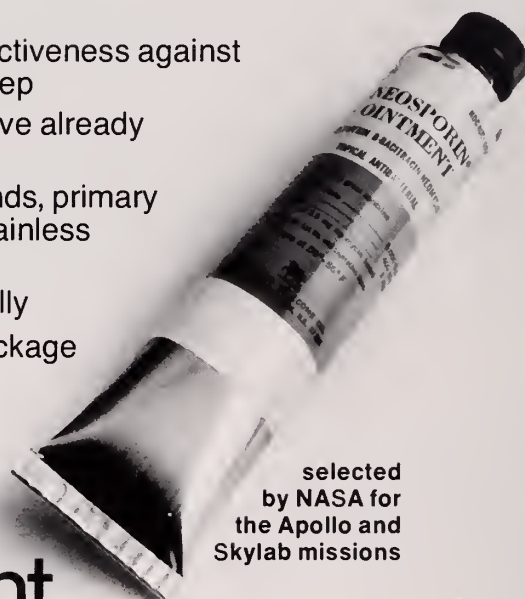
Polymyxin B

Neomycin

Bacitracin

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Pseudomonas
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Klebsiella
Aerobacter
Escherichia
Proteus
Gram-positive
Corynebacterium
Staphylococcus
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1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
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by NASA for
the Apollo and
Skylab missions

NEOSPORIN[®] Ointment (polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin[®] (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

NEWSLETTER

February 1980

Dear Doctor:

The soaring price of silver has produced a flourishing black market in stolen unprocessed x-ray film and even old x-rays, creating security problems for some of the nation's hospitals, reports "Newsweek." Since ten pounds of used x-ray film - about 100 sheets - contain more than an ounce of pure silver (worth about \$35), and since the reclamation process is relatively simple, thieves have been quick to capitalize.

Security procedures have been stepped up in many hospitals. "We now treat x-ray film like we treat narcotics," one administrator stated. Houston's Methodist Hospital now stamps "stolen from Methodist Hospital" on x-ray film to deter thieves. So far, Mississippi hospitals have reported no problems with stolen film.

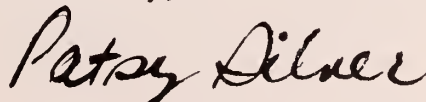
So far, there is no evidence that mandatory second opinions for elective surgery would save money, a Carter administration witness told the House Subcommittee on Civil Service. The administration said more time should be given to various government sponsored demonstration projects before undertaking any national mandatory program such as the one the subcommittee was considering.

Five lawsuits have been filed against Aetna Life & Casualty, alleging that the firm tampered with juries through two public issues statements the company ran in national magazines. The ads stated that justified claims should be fairly compensated, but deplored state laws which permit "excessive and unwarranted awards." The suits were filed by plaintiffs in damage suits.

The Child Health Assurance Program (CHAP) which Congress is expected to pass this session will have a dramatic impact in Mississippi. CHAP will extend Medicaid coverage to new groups of mothers and children. Physicians agreeing to give basic primary and preventive care to CHAP eligible children on a continuing basis will receive reimbursement incentives.

Look for the next big controversy under the health planning law to involve Health Systems Agency and state agency reviews of the appropriateness of existing hospital and nursing home services. HEW's Bureau of Health Planning recently issued final regulations for such review. One was observed that "what government giveth under certificate of need can now be taken away under appropriateness review."

Sincerely,



Patsy Silver
Managing Editor

1950s
1960s
1970s
1980s
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with . . .

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

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In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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DATELINE

Supervisors Told Jackson, MS - Ella Tardy, coordinator for MSMA's Jail
Jail Health Needs Health Project, was among panelists discussing "Legal
Issues in Jails" at the Mississippi Association of
Supervisors' Mid-Winter Conference on County Government. Other panelists were
W. V. (Chip) Westbrook of the Attorney General's Office; Dennis Cahill, Warren
County Jail Administrator; Patricia Newman of the Mississippi Department of Youth
Services and Jesse R. Greer of the Cooperative Extension Service, MSU.

Dale Supports Jackson, MS - A news report in the Jackson "Clarion
Chiropractic Bill Ledger" states that Commissioner of Insurance George
Dale supports legislation sponsored by a 173-member
state chiropractic association to require all health insurance policies sold in
Mississippi to pay for chiropractic services. A chiropractic spokesman said
such a requirement would not increase health insurance costs. Commissioner Dale
says it would.

Home Health Chicago, IL - Physicians who want to learn more about
Guide Offered home health services will be interested in reading the
"Physician Guide to Home Health Care," recently pub-
lished by the AMA. The brief and informative publication discusses such subjects
as how to assess home agency services and how to write a plan of care. To
order, send \$1.00 to Order Department, OP-077, American Medical Association,
P. O. Box 821, Monroe, WI 53556.

Hospice Demonstration Washington, DC - Beginning in March, HEW will pay for
Announced all hospice care provided to terminally ill Medicaid
patients by 26 hospice organizations selected to par-
ticipate in a two-year demonstration project. "We will waive limitations that
now prevent reimbursement for such services...to explore the possibilities of
making changes in current Medicare and Medicaid regulations," said HCFA admini-
strator L. D. Schaeffer. The 26 organizations were selected from 236 applicants.

UM Graduate Nursing Jackson, MS - The University of Mississippi School of
Program Accredited Nursing master's program in nursing has received a
maximum eight year accreditation from the National
League for Nursing. The NLN Board of Review for Baccalaureate and Higher Degree
programs recently notified the school of its action on the graduate program. The
agency also granted the UMC school's baccalaureate program continuing accredita-
tion for the maximum eight years.

POSTGRADUATE CALENDAR

March 13-15, 1980

SURGICAL FORUM VII

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: James D. Hardy, M.D., professor of surgery and chairman of the department, University of Mississippi School of Medicine.

This seventh annual forum is for the general surgeon. Internationally recognized guest lecturers will join UMC faculty members in presenting sessions during the three-day program. Fee: \$175. Credit: 17 contact hours (1.7 CEU) Category I of the Physician's Recognition Award, AMA.

March 27-28, 1980

CLINICAL NEUROLOGY REVIEW

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Shri K. Mishra, M.D., assistant professor of neurology, University of Mississippi School of Medicine, and neurology service chief, Veterans Administration Medical Center.

This two-day program is designed for the family and general medicine practitioner, neurologist, neurosurgeon, internist, psychiatrist and pediatrician. Sessions will focus on recent advances in diagnosis and treatment of common neurological disorders of higher cortical functions. Fee: \$125. Credit: 13 contact hours (1.3 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

April 3-4, 1980

INFECTION IN THE NEWBORN

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the Division of Newborn Medicine, School of Medicine; and Gwen Bussa, R.N., M.N., C.N.M., assistant professor, School of Nursing, and instructor in obstetrics and gynecology (nurse-midwifery), School of Medicine.

Sessions will include normal immunological responses of the fetus and newborn. Pathophysiological response of the infected newborn will be emphasized. Current methods of medical intervention will be discussed. The course is limited to 10 participants. Fee: \$50. Credit: 12 contact hours (1.2 CEU), Category I of the Physician's Recognition Award of the AMA; AAFP credit applied for.

April 10-12, 1980

LIVER DISEASE UPDATE

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine Division of Digestive Diseases, the American College of Gastroenterology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: James L. Achord, M.D., professor of medicine and director, Division of Digestive Diseases, University of Mississippi School of Medicine.

The program will review new concepts in hepatology and their clinical application. Medical and, where appropriate, surgical aspects of liver disease will be discussed. Fee: \$150. Credit: 14.5 contact hours (1.45 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

FUTURE CALENDAR

April 25-26, 1980

**ADVANCED CARDIAC LIFE SUPPORT PROVIDERS
COURSE**

Forrest General Hospital, Hattiesburg, MS

May 6-10, 1980

HAND SURGERY

Ocean Springs, MS

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.



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**When painful spasm
is the presenting
symptom...**



...in the functional bowel/irritable bowel syndrome*

Bentyl[®]

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl[®]

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiltwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Ocaturo, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Arthritis Symposium Is Planned

The Fifth Annual Symposium on Arthritis and Musculoskeletal Diseases, co-sponsored by the Mississippi and South Alabama Chapters of the Arthritis Foundation, is scheduled for April 11-13 at the Grand Hotel in Point Clear, AL.

The symposium will consist of three half-day sessions designed to bring to physicians and allied health professionals developments in treatment and research.

The program is acceptable by the AMA for Category 1 CME credit on an hour for hour basis.

For more information, contact the Mississippi Chapter, Arthritis Foundation, 6055 Ridgewood Rd., Jackson, MS 39211.

Gift Provides UMC Video Playback System



Physicians attending the University of Mississippi Medical Center's Family Practice Update in Jackson were able to pick up extra continuing education credit during the November seminar. Videotaped programs were fed through the cable television system at the Holiday Inn Medical Center, headquarters for the three-day session, so physicians could view the tapes in their hotel rooms. The UMC Division of Learning Resources coordinated the effort. The playback system was assembled by the Medical Center's television production center. The project was made possible by the Brock Continuing Education Fund of the L. W. and Dannie T. Brock Scholarship Fund. Dr. Ralph Brock, right, of McComb, the Brocks' son, was on hand for the initial viewing. With him are, from left, Jim Worley, UMC TV production chief, and Dr. Wallace Conerly, director of Continuing Health Professional Education.

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Mississippi's Unique Psychiatric Hospital.

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As a privately owned 56-bed short term care facility for treating patients with psychiatric illness, emotional problems, or substance abuse, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

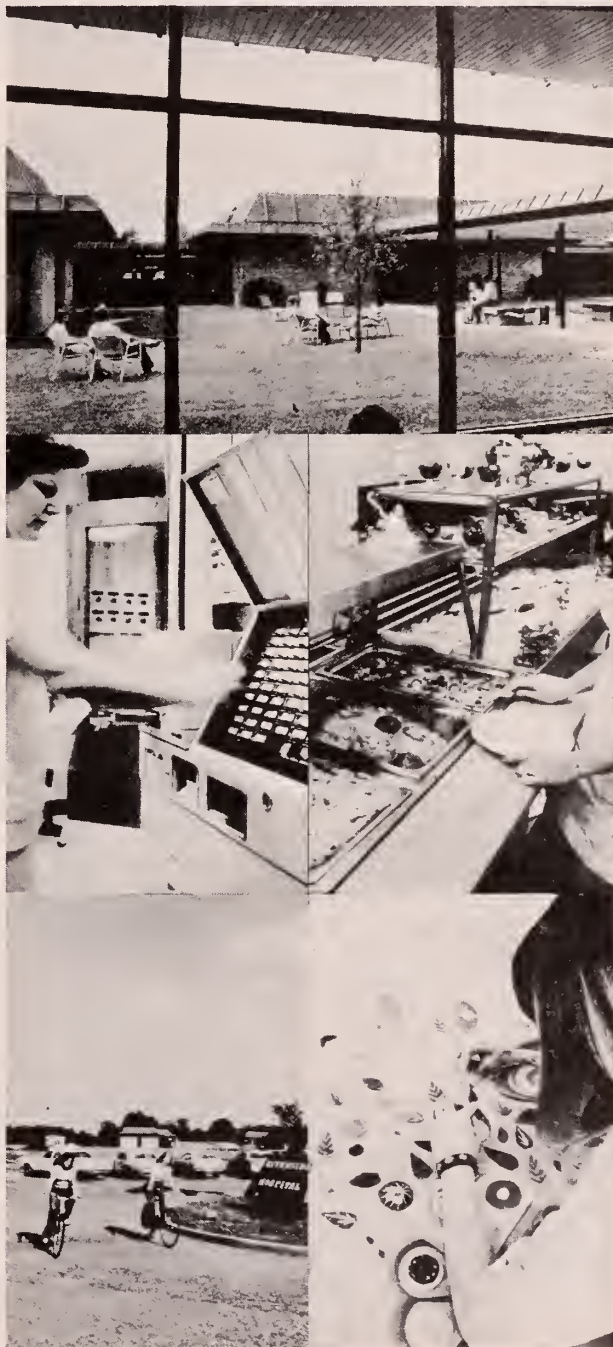
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.

Riverside Hospital

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V-Cillin K[®]

penicillin V potassium

is the most
widely prescribed
brand of oral penicillin



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V-CILLIN K
C 29

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125 and 250 mg */5 ml

V-Cillin K[®] penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies

before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (1021751)

***Equivalent to penicillin V.**

Additional information available to the profession on request.



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ORIGINAL PAPERS

Nuclear Imaging of the Heart

OTTIS G. BALL, M.D.

Jackson, Mississippi

NUCLEAR MEDICINE STUDIES are good screening procedures. The isotopic images obtained are helpful in visually displaying physiological function. With the advent of more sophisticated electronics and computer analysis, nuclear medicine now is being applied to the evaluation of cardiovascular function. This has been aided by the development of some newer isotopes and isotope techniques.

Isotope Ventriculogram

In 1971 Zaret et al¹ described their initial experience with isotope scanning for detection of regional ventricular dysfunction in man. Since that time many major medical centers have developed a technique for performing this noninvasive procedure. The isotope ventriculogram is a relatively simply performed study that requires no patient preparation. The procedure may be performed in the nuclear medicine department or with the mobile camera, in the patient's room or intensive care unit.

A 1.5 mg dose of phosphate is administered intravenously to sensitize the patient's red blood cells. A few minutes later an intravenous injection of about 15 millicuries of Technetium 99M pertechnetate is given to label these blood elements (in vivo red blood cell labeling). Images of the cardiac blood pool are then obtained with the scintillation camera usually in the left and right anterior oblique positions. These EKG monitored or gated images are fed into a dedicated computer for data analysis. Through a series of computer commands, a left ventricular ejection

fraction may be calculated. This is based on the formula:

$$\frac{\text{End diastolic volume} - \text{End systolic volume}}{\text{End diastolic volume}} = \text{Ejection fraction}$$

These rapidly acquired images may then be displayed on video tape in a cinegraphic mode for evaluation of ventricular wall motion.

In recent years, technological advances in nuclear medicine have increased its application to the evaluation of cardiovascular function. The author describes three nuclear screening procedures which may be useful diagnostic aids when used in conjunction with studies of clinical findings and other laboratory techniques, both invasive and noninvasive.

Reproductions of two polaroid print readouts obtained from the computer oscilloscope are shown in Figure 1. The one to the left (A) indicates the ejection fraction (E.F. = 0.76) and other data. A composite image of the heart is shown in LAO projection with left and right ventricles separated and with the area of interest used to calculate the ejection fraction delineated. The time-activity curve generated is displayed in the lower left. The one to the right (B) is a computer banded image of the heart in LAO projection, with the systolic and diastolic phases superimposed to demonstrate the degree of contractility of the ventricles.

From the Department of Nuclear Medicine, Mississippi Baptist Medical Center, Jackson, MS.

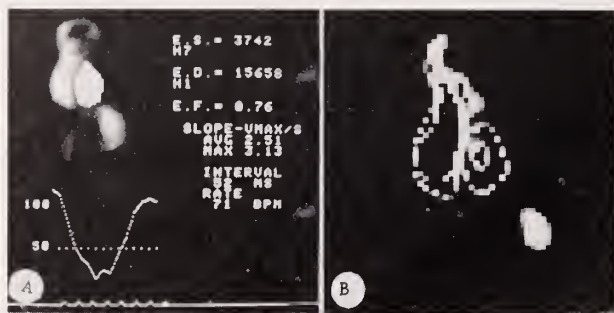


Figure 1. Normal Isotope Cardiac Ventriculogram.

Thallium Cardiac Perfusion Scans

Isotopes of potassium, rubidium, and cesium have been employed in the past for the study of coronary blood flow and myocardial cell viability.² In 1973 Lebowitz et al, reported their successful use of Thallium-201 in performing myocardial scans in animals.³ Later Strauss, Pitt,⁴ and others⁵⁻⁶ reported the clinical usefulness of thallium perfusion heart scans in man for the evaluation of cardiac ischemia and infarction.

This is a helpful screening procedure which is usually performed in conjunction with the ECG stress test. The patient undergoes a regular treadmill ECG monitored stress test. At peak stress a 1.5 millicurie dose of Thallous-201 chloride is given intravenously, and the stress is continued for another

thirty seconds. As soon as possible after this, images of the heart are obtained. At least three views are required to adequately display the walls of the left ventricle — anterior and approximately 45° and 60° left anterior oblique positions. This ordinarily takes about thirty minutes of imaging time. Three hours later redistribution images are obtained.

This noninvasive physiological study adequately indicates blood flow to the various portions of the left ventricle and also depicts viable areas of myocardium.

Thallium, an analogue of potassium, is rapidly extracted from the blood by viable myocardial cells in direct proportion to the amount of blood flow. Therefore, the early images are able to depict areas of ischemia as areas of relative decreased activity. The delayed images confirm this by demonstrating the eventual accumulation of activity in these areas. However, the presence of persistent decreased activity in an area indicates an area of non-viable cells or an infarction.

Figure 2 illustrates the polaroid images from a normal study with labeled line drawings present below each of the three images. In the anterior view (A-A'), the left ventricular anterolateral wall, apex, and inferior wall are well seen. The left ventricular cavity appears as a region of reduced activity between these structures. The 45° left anterior oblique view (B-B') is best for visualization of the septum. The septum and posterolateral walls extend up from

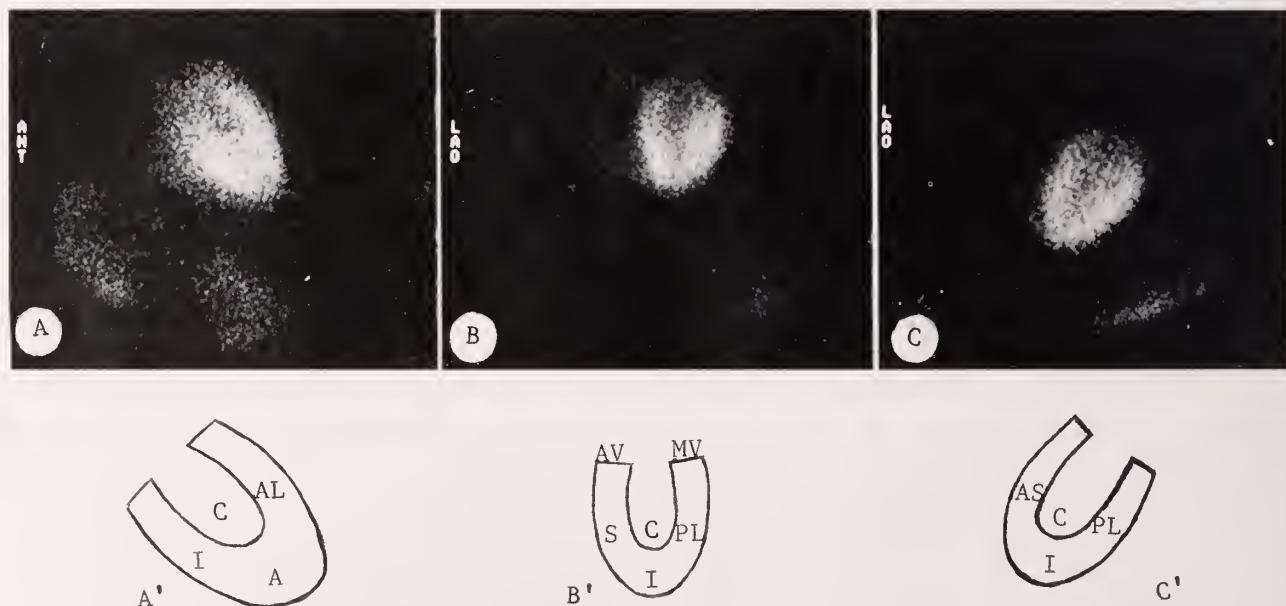


Figure 2. Normal Stress Thallium Heart Scan. Actual perfusion images are shown in the anterior (A), 45° LAO (B), and 60° LAO (C) positions. Labeled line drawings (A', B', C') are indicated below each view. (AL = anterolateral; A = apical; I = inferior; C = cavity of left ventricle; MV = mitral valve; PL = posterolateral wall; I = inferior; S = septum; AV = aortic valve; AS = anteroseptal.)

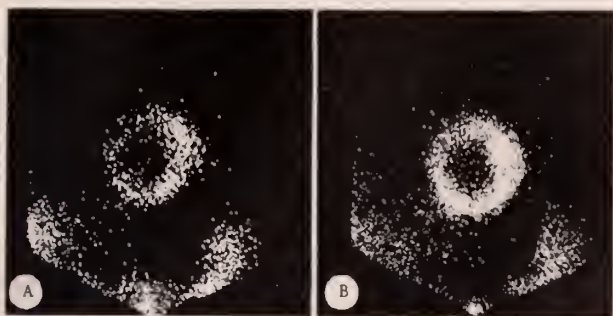


Figure 3. *Septal Ischemia. (A) Immediate post stress image in 45° left anterior oblique position; (B) Delayed redistribution image in 45° left anterior oblique position.*

the inferior wall to the regions of the aortic and mitral valves. The 60° left anterior oblique (C-C') is the best view to demonstrate the posterolateral wall, and it aids in the interpreting of the other views with respect to the anteroseptal and inferior walls.⁵

Septal ischemia is illustrated in Figure 3 with a 45° left anterior oblique projection obtained ten minutes post stress (A), and the same projection obtained three hours later (B) (redistribution image). Note the initial relative decreased activity in the septum with an increase in activity in this region on the delayed image.

A resting thallium study alone, without stress, may be performed for evaluation of myocardial infarction (cold spot images). However, acute and chronic damage cannot be distinguished. To determine whether a perfusion defect is acute, other data such as serial electrocardiographic or enzyme studies or infarct avid scanning with Technetium 99M pyrophosphate must be performed.⁴

Acute Cardiac Infarct Scanning

In 1974 Bonte et al⁷ described the use of Technetium 99M pyrophosphate for the purpose of imaging acute myocardial infarcts.

Apparently microscopic hydroxyapatite crystals are deposited within dying myocardial cells shortly after vascular occlusion. It was found that pyrophosphate will be deposited in these areas of crystalline formation when administered within an appropriate time interval, usually 48 hours to 14 days post infarction.

This study may also be performed with the mobile scintillation camera. A 15 millicurie dose of Technetium 99M labeled pyrophosphate is administered intravenously and images of the cardiac region are obtained in the anterior, left anterior

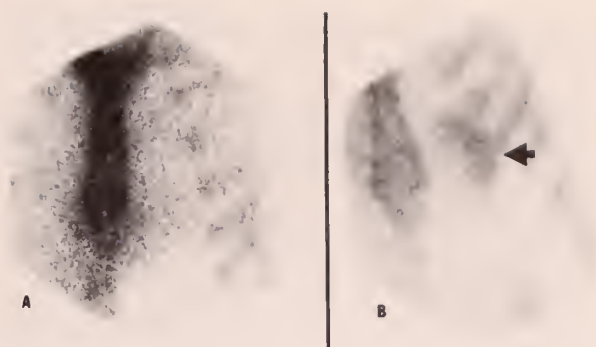


Figure 4. *Pyrophosphate Heart Scan. (A) Normal scan with increased activity only in ribs and sternum; (B) Abnormal scan with prominent focus of increased activity in the anterolateral wall of the left ventricle.*

oblique, and left lateral positions at about 2-4 hours post injection. The area of infarction is depicted as an area of increased activity (hot spot imaging). This area of abnormal activity is as great or greater in density than that in the adjacent ribs or sternum.

A negative (A) and a positive (B) "hot spot" image of two patients suspected of having an acute myocardial infarction are shown in Figure 4.

Discussion

It is evident that nuclear medicine has come a long way in recent years in the physiological imaging of the heart. However, these are screening procedures. They are diagnostic aids that may be used in conjunction with clinical findings and the laboratory studies such as serum enzymes, electrocardiography, and echocardiography, as well as the invasive studies such as coronary angiography and contrast ventriculography.

The isotope ventriculogram truly meets the criteria of a screening procedure in that it is accurate, simple, safe, and relatively inexpensive. However, the thallium study fails to meet the criteria in that it is less specific and accurate (especially without stressing) and remains relatively expensive because of the cost of the isotope. The thallium study does increase the overall accuracy of the ECG stress test, particularly in regard to a false positive test in women. It is also quite helpful in the evaluation of patients who have an abnormal resting ECG or a left bundle branch block. It may also be of value in the evaluation of post coronary artery bypass surgery patients.

The pyrophosphate heart scan is useful in patients who are first seen several days (2-14 days) post infarction, at which time their serum enzymes may have returned to normal and the ECG is non-diagnostic. However, a fairly high rate of false positives has been reported. Therefore, the ideal isotope

for cardiac perfusion evaluation and infarct detection has yet to be found.

Summary

Nuclear medicine has come of age in regard to cardiovascular analysis and yet it has a way to go in establishing itself in this very important area of patient care. The isotope ventriculogram does demonstrate heart wall motion and does accurately estimate the cardiac ejection fraction. The thallium heart scan does increase the accuracy of the stress ECG test. The pyrophosphate heart scan may aid in the evaluation of acute myocardial infarction. ★★★

1225 North State Street (39201)

Acknowledgements

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Radiologic Seminar CXCIX: Improved Thyroid Uptakes and Scans With Iodine-123

FRED G. EMRICK, M.D., and
W. MEL FLOWERS, JR., M.D.
Jackson, Mississippi

MOST CLINICIANS are well aware of the value of Iodine-131 for the evaluation of thyroid disease, particularly for radioactive iodine uptakes and scans. It is not generally known that Iodine-123, an almost ideal radioactive iodine isotope, is now available. The combination of its desirable physical characteristics and ease of imaging outweigh its relatively few disadvantages.

Sodium Iodine-123 was first used in 1961 by Dr. William G. Myers on a large dog.¹ It decays by electron capture and there is no beta radiation. The photon emission of 159 keV is in the range of the ideal photon, and is easily and efficiently collimated and detected.² Iodine-123 can be imaged by both the rectilinear scanner and the gamma camera. The usual scanning and uptake dose of Iodine-123 is 200 to 400 microcuries; this results in a radiation dose of less than 5 rads to the thyroid gland.

By extrapolating these physical properties into clinical practice, the advantages are clear. The relatively short half-life, combined with lack of beta particle emission and the low-energy gamma photons, results in a low radiation dose. The possibility of a decreased dose is of particular concern for all diagnostic evaluations. Because of the lower radiation dose, a larger amount of the radionuclide can be given, resulting in faster scans and the possibility of repeat scans at frequent intervals. Initial clinical experience indicates that very adequate scans can be obtained at 4 to 6 hours after initial dose; this was not possible with Iodine-131. The isotope is particularly advantageous to the smaller hospital, which usually has only a single type of imaging device. The Iodine-123 photon energy of 159 keV allows use of either the gamma camera or rectilinear scanner. Iodine-123 allows for better resolution than

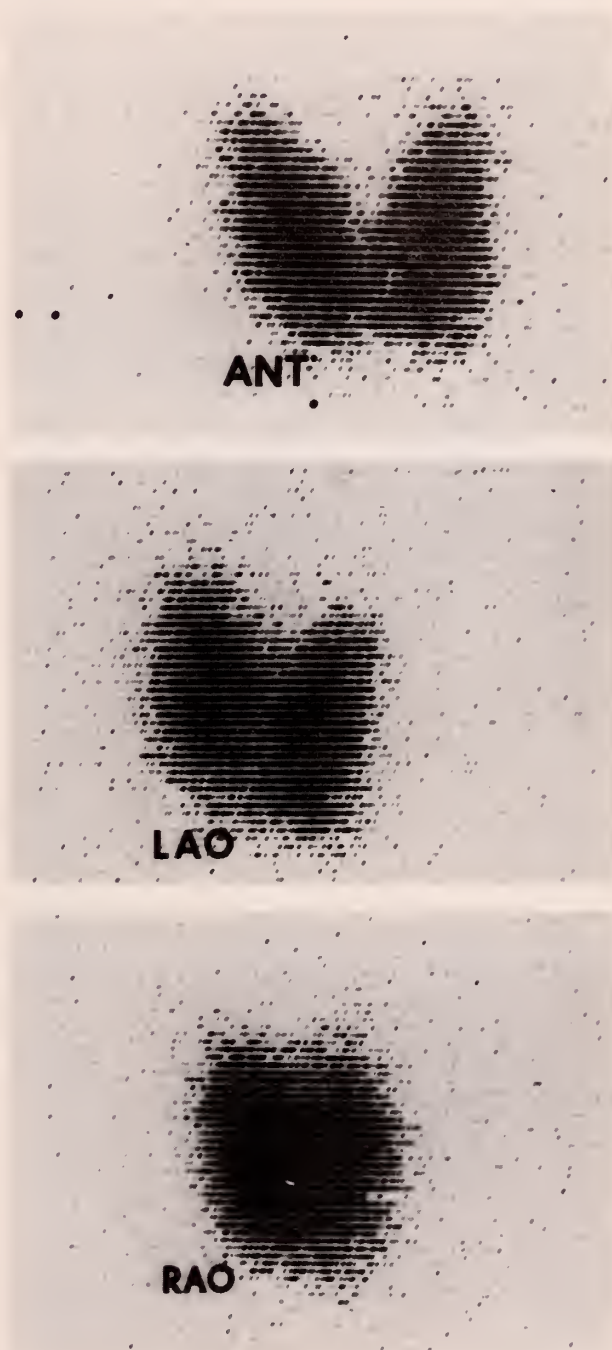


Figure 1. Normal Iodine-123 thyroid scan shown in anterior and both oblique projections. The study was obtained with a rectilinear scanner.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University of Mississippi
Medical Center, Jackson, MS.

Iodine-131 because of its lower energy gamma emission.³ An example of this difference can be seen in the comparison of the scans in the accompanying illustrations. Iodine-123 is also superior to Technetium-99m for complete evaluation of the thyroid and its complex interrelationships, especially in the work-up of "hot" and "cold" thyroid lesions.¹

The disadvantages of Iodine-123 are few. The commercial product is not free of impurities. Iodine-123 is cyclotron produced, and long lived radionuclide contaminants such as Iodine-124 (half-life, 4.2 days) and Iodine-126 (half-life, 13 days) have been found.⁴ However, newer methods of cyclotron generator production may minimize this problem.⁵ Additional disadvantages are the relatively high production costs and the short physical

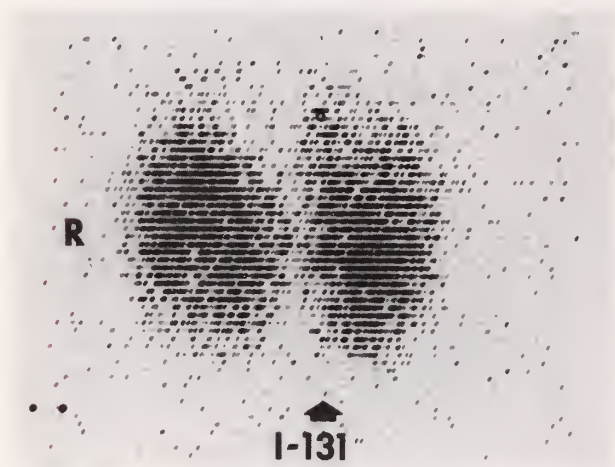


Figure 2. Diffusely enlarged thyroid gland in a patient with hyperthyroidism. The scanning agent is Iodine-131.



Figure 3. Same patient as in Figure 2. Notice the improved overall appearance of the scan. This is primarily due to the increased count density from the superior scanning agent Iodine-123.



Figure 4. Iodine-123 scan showing a single cold nodule in an enlarged right thyroid lobe. It is impossible to determine from any given thyroid scan whether such a nodule is benign or malignant. A single palpable cold nodule has a malignancy rate of about 20%.

half-life which increases cost when significant shipping times and distances are involved. However, the important radiation dose reductions with the use of Iodine-123 will usually offset the problems of cost versus benefit.

Iodine-131 remains the best available agent for radioactive iodine therapy because the disadvantage of increased radiation dose for diagnostic studies becomes an advantage when delivering a dose for therapeutic effect.

In conclusion, Iodine-123 is an excellent radionuclide for thyroid studies. Its advantages of decreased radiation dose, multiple means of imaging, better resolution, and faster scanning overshadow the disadvantages of minor impurities, modest expense and universal accessibility. ★★★

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Special Article

National Health Service Corps: Boon or Boondoggle?

PATSY SILVER

In its short seven-year history, the National Health Service Corps (NHSC) has become a major federal effort to help meet health care needs in medically underserved areas. What began in 1972 as an experiment with 19 volunteers has grown to a current field strength of about 1,500 health care providers, half of whom are physicians. By 1985 there will be an estimated 8,000 federally salaried physicians and other health care professionals serving in the NHSC.

Purpose

The NHSC was established by the 1970 Emergency Health Personnel Act. Its purpose, as stated by Congress, was "to authorize the assignment of commissioned officers of the Public Health Service to areas with critical medical manpower shortages and to encourage health personnel to practice in areas where shortages of such personnel exist . . ." Physicians were to be recruited through the mechanisms of guaranteed salaries and medical scholarships to serve in critical health manpower shortage areas to be defined under guidelines issued by the Department of Health, Education and Welfare.

At its implementation two years later, the NHSC had received the support of organized medicine. The MSMA House of Delegates endorsed the program in a 1971 action. The American Medical Association added its endorsement the following year. The AMA's "Project America" program was established to provide temporary physician assistance to those NHSC sites whose physicians were away on vacation or taking continuing education courses.

Changes in Original Program

The National Health Professions Education Assistance Act of 1977 made significant changes in the NHSC program. More areas were designated as health manpower shortage areas, state mental hospitals and prisons were added to the list of appropriate placement sites, and the scholarship program was greatly expanded. The law made another change which has been responsible for the growth in field strength. Under the original NHSC plan, many scholarship recipients had been exercising the buy-out option rather than paying back their scholarship

obligations by service in the field, so the 1977 legislation enacted regulations and penalties designed to discourage this practice. Students exercising the buy-out option now must pay back three times the amount of financial aid at 14% interest, within the first year.

The scholarship program has become increasingly attractive to medical students as tuition costs increase and as other sources of financial assistance, both governmental and private, become less available. Last year the Department of HEW awarded \$75 million (a 25% increase over the previous fiscal year's funding) for 6,408 NHSC scholarships for the 1979-80 school year. Of these, 2,379 were new participants in the program; the remainder were continuations. The scholarships were awarded to students in 12 health disciplines: medicine, osteopathy, dentistry, podiatry, baccalaureate nursing, master's level nurse practitioner, master's level public health nutrition, community health nursing, nurse-midwifery, pharmacy, veterinary medicine and optometry.

Competition for the scholarships (averaging \$12,000 per year for each recipient) is growing. Last year some 4,000 applicants sought the 1,100 new scholarships available to medicine and osteopathic students. The NHSC now awards scholarships to 6.4% of medical students. To reach field strength goals, it soon will have to give scholarships to 15% of medical students, it is estimated.

Whether obligated by scholarship aid or recruited after their training, NHSC physicians agree to provide primary medical care in one of the 1,500 federally designated health manpower shortage areas. They are salaried at \$21,000 to \$36,000 (except those working in a few sites which fulfill criteria for exercising the new "private practice option"). The communities set up and staff a clinic, often with NHSC financial aid or assistance from other government programs.

NHSC in Mississippi

In Mississippi, all or parts of 59 counties have been designated as primary medical care shortage areas. At the present time there are 62 NHSC assignees at work in some of these areas. Twenty-three are physicians and 20 are nurse practitioners. The remainder are registered nurses, osteopaths, physician assistants, dentists, nurse midwives, nutritionists and administrators.

A number of the NHSC physicians in Mississippi, in interviews with JOURNAL MSMA, indicated that they intend to remain in their communities when their service obligations are completed. Some will

NHSC / Continued

reenlist in the NHSC; others will establish private practices in their areas. Several have taken steps to join MSMA. None of the physicians that JOURNAL MSMA talked with indicated that they had encountered problems NHSC physicians in other areas report, although several acknowledged that the problems do exist in some areas.

Problems in NHSC

The NHSC program is not without problems, some internal and some external.

Misunderstanding on the part of some students about deferments for subspecialty training, objections to the expensive buy-out option by students who have changed their minds, and physician and spouse dissatisfaction with placement sites are problems which the NHSC is seeking to prevent by an expanded orientation and acclimation program. Confusion about the fundamental purpose of the NHSC may be clarified by a new emphasis on its role as a program to supply health professionals to shortage areas rather than a financial aid source for medical students.

As in most government programs, the NHSC is

subjected to influence from several federal departments. Administrative control is actually split between the Health Resources Administration and the Health Services Administration. Bureaucratic inconsistency and indecision has been reported in some accounts of operations of the program.

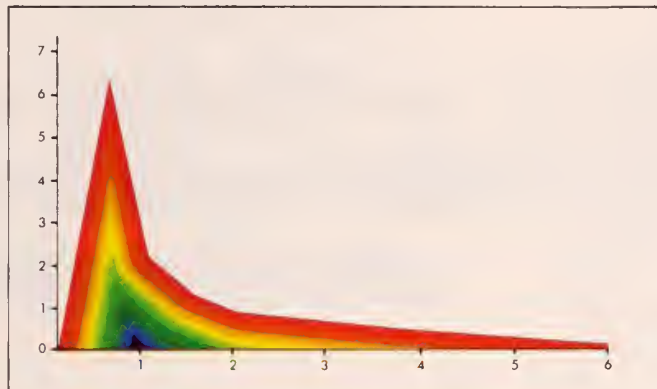
The NHSC has been criticized for its retention rate. Project spokesmen term the retention rate "better than what could be expected," and point to the fact that 40% of Corps physicians reenlist when their obligations are finished and another 10% remain in the area in private practice. A lower patient load when compared to the national average has been another criticism.

Role of Medical Community

Conflict often arises between NHSC and established physicians over proper utilization and placement of Corps physicians. The placement process permits input from the medical community at several times: when an area is designated a critical manpower shortage area; when an area so designated makes application for designation as a NHSC site; and when a physician is placed at the site. By exercising these opportunities to provide input, the medical community can have a role in assuring proper utilization of NHSC personnel.

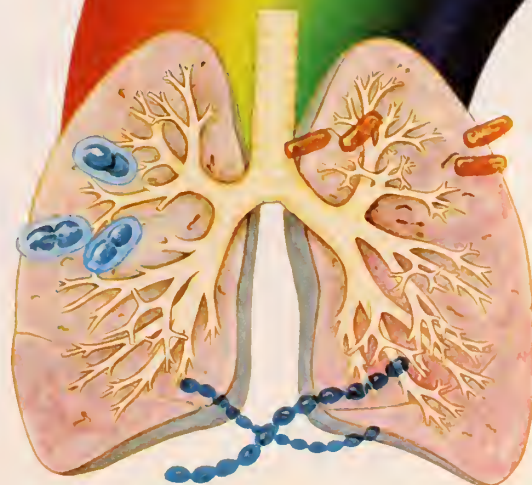
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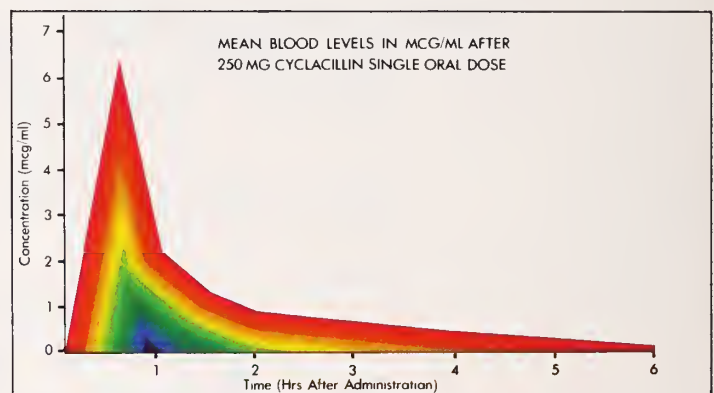
efficacy with fewer side ampicillin confirmed in studies of 2,581

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(clinical efficacy may not
always correlate with
blood levels)

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1½ times faster than
ampicillin



Clinical efficacy of CYCLAPEN[®] in otitis media[†]

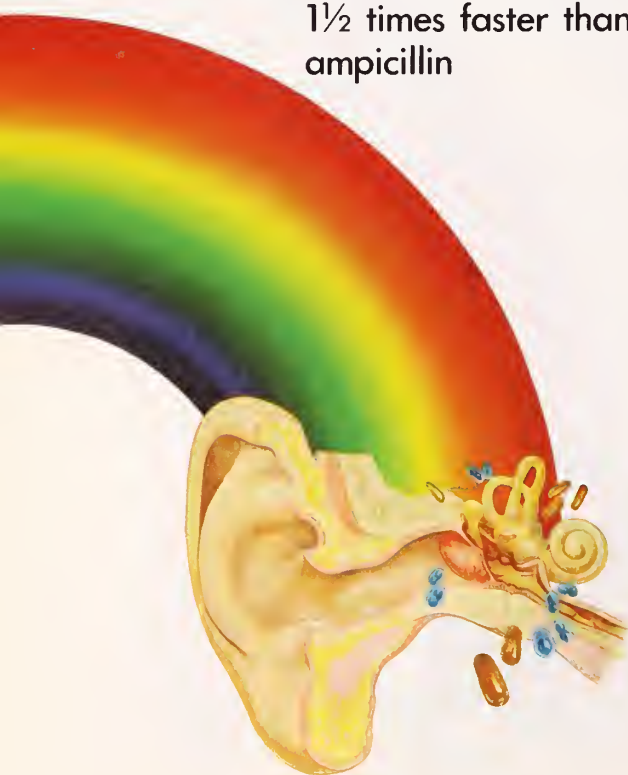
Causative Organism		No. of Patients
<i>S. pneumoniae</i>	96	82
	95	
<i>H. influenzae</i>	88	96
	85	
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>		

more than just spectrum in otitis media

*Includes all patients treated. 2,415 evaluated for safety;
1,819 evaluated for efficacy.

†Due to susceptible organisms.

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effects than double-blind patients*

Fewer side effects with CYCLAPEN® in double-blind studies to date^{1,2}

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant ($P < 0.001$)	

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CYCLAPEN	9.1%	2.1%
ampicillin	19.2%	5.8%
	$P < 0.001$	$P < 0.03$

1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.

2. Data on file, Wyeth Laboratories.

(See important information on next page.)



In bronchitis, pneumonia and upper respiratory tract infections[†]

High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
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Chronic Bronchitis† (acute exacerbation)		
<i>H. influenzae</i>	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to <i>H. influenzae</i> .	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100	44
	86	
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>		

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Cyclapen[®] (cyclacillin) has less *in vitro* activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below

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RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS. SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN. ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated

CYCLAPEN[®] (cyclacillin) for oral suspension

125 mg per 5 ml:

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250 mg per 5 ml:

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hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration INFECTION* ADULTS

Respiratory Tract Infections and Pharyngitis** 250 mg q.i.d. in equally spaced doses

Bronchitis and Pneumonia

Mild or Moderate Infections 250 mg q.i.d. in equally spaced doses

Chronic Infections 500 mg q.i.d. in equally spaced doses

Otitis Media 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity

Skin & Skin Structures 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity

Urinary Tract 500 mg q.i.d. in equally spaced doses

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure
Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥10 mg %, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

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MEETINGS

National and Regional

American Medical Association Winter Scientific Meeting, January 12-15, 1980, San Antonio, TX; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 1980, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 112th Annual Session, April 27, 1980, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. W. W. East, Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Paul Mink, Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Thomas Waller, Secy., P.O. Box 1487, Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Clyde Allen, Secy., 1245 N. 6th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly Mississippi State Medical Association 735 Riverside Drive Jackson, MS 39216	Northwest Mississippi Regional Medical Center Box 1218 Clarksdale, MS 38614
North Mississippi Medical Center 830 Gloster Avenue Tupelo, MS 38801	Mississippi Chapter American College of Surgeons Box 5229 Jackson, MS 39216
Forrest General Hospital Box 1897 Hattiesburg, MS 39401	Mercy Regional Medical Center 100 McAuley Drive Vicksburg, MS 39180
Mississippi Baptist Hospital 1225 N. State Street Jackson, MS 39201	St. Dominic-Jackson Memorial Hospital Lakeland Drive Jackson, MS 39216
Gulf Coast Community Hospital 4642 W. Beach Boulevard Biloxi, MS 39531	North Panola County Hospital Drawer 160 Sardis, MS 38666
Jefferson Davis Memorial Hospital Box 1488 Natchez, MS 39120	Singing River Hospital 2809 Denny Avenue Pascagoula, MS 39567
King's Daughter Hospital Box 948 Brookhaven, MS 39601	Magnolia Hospital Alcorn Drive Corinth, MS 38834
Delta Medical Center Greenville, MS 38701	Greenwood Leflore Hospital 1508 Leflore Avenue Greenwood, MS 38930
Riverside Hospital Lakeland Drive Jackson, MS 39208	



The President Speaking

Let's Plan for a Great Convention

GERALD P. GABLE, M.D.
Hattiesburg, Mississippi

The time is rapidly approaching for MSMA's 112th Annual Session, to be held at the Biloxi Hilton Apr. 27-May 1. The Council on Scientific Assembly, which is responsible for planning the Annual Session, has gone "all out" to plan a great meeting, and all members should begin now to plan to attend. Hotel reservation forms will be mailed out in the Feb. 15 "Blue Sheet," so that everyone will have time to arrange family and business activities so that they may attend.

In an effort to improve and update the meeting, the Council has changed the format of the convention somewhat this year to have a "business with pleasure" meeting. Business and scientific programs are scheduled for the morning meetings, leaving afternoons free for members and families to have more time together for tennis, golf, shopping and other recreational, fellowship activities and relaxation.

The format of the morning meetings will also be somewhat changed by introducing a more general scientific program designed to appeal to a broader number of association members. Several combined Sections are planning the scientific programs for Sunday, Tuesday and Wednesday mornings, with specialty societies holding breakfast and noon luncheon meetings. The House of Delegates will meet as usual on Monday and Thursday mornings, and Reference Committees will meet Monday afternoon. Tennis and golf tournaments are scheduled for Tuesday afternoon and a Practice Management Breakfast-Seminar is scheduled for Wednesday morning.

One of the social highlights of the meeting will be a dinner on Wednesday evening featuring an address by nationally known news broadcaster Howard K. Smith. It is hoped that all of the members will plan to make this a big success. The members of the Auxiliary particularly have been in favor of this type of function, permitting attendance with their spouses, rather than their usual separate luncheon and style show meeting. So be prepared for your wife or other Auxiliary member to sell you a ticket. Let's all plan a fun and fellowship evening together on this occasion, as well as hear an outstanding and informative national speaker.

I look forward to seeing you *all* at the convention. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 2

FEBRUARY 1980

Federal Trade Commission

An editorial in the July 1978 issue of JOURNAL MSMA outlined many of the recent decisions and activities within the Federal Trade Commission to limit and alter the practice of medicine in the United States. Since that time, these activities have increased tremendously, and as a result there has been counteraction to attempt to control the FTC. The following report outlines an action taken within the Congress of the United States to limit the activities of the Federal Trade Commission as it relates to the practice of medicine. Every physician in this state should review the following report and respond promptly by contacting their Senators and Congressmen regarding this matter.

The current activities of the Federal Trade Commission (FTC) are among the hottest issues now before Congress. The FTC increasingly is substituting its judgement for that of the Congress and the states, and pressure is building for Congress to act to restrict the FTC's authority and activities. Because of increasing Congressional concern with FTC's activities, the Commission has not had an authorization enacted for the past three years. The House on November 27, 1979 passed HR 2313, placing substantial limitations on the FTC. The Senate will soon be considering S 991, which also contains many important restrictions on the FTC.

Among the limitations to the FTC's authority proposed in S 991 are the following: restrictions on the scope of subpoenas issued by FTC; a requirement that the agency prepare a regulatory analysis when initiating a rulemaking proceeding; payment of attorneys' fees for certain parties (i.e., small businesses) prevailing over the FTC; and mandatory Congressional oversight hearings on the FTC every six months.

While these proposals are encouraging, additional provisions are necessary to clarify that the FTC does not have the authority to regulate the medical, dental and legal professions or to preempt state regulation of these professions.

Senators McClure of Idaho and Melcher of Montana will offer such an amendment to S 991 when the bill comes up for a vote on the Senate floor.

The McClure-Melcher Amendment states that the FTC could not use any of its funds "for the purpose of inves-

tigating, or taking any action against, or promulgating any rule or regulation . . . with respect to any legal, dental, medical or other state regulated profession, or with respect to its state or national professional associations."

This amendment, if adopted, would reaffirm in the states their traditional authority to regulate the professions. The FTC increasingly is trying to usurp this authority, even though state regulation has served the public interest well. The amendment would also protect professional societies from unwarranted federal government interference with their proper activities. This is an important amendment to all professionals and should be adopted.

The report was issued Nov. 29, 1979, by the Public Affairs Division, Legislative Department, American Medical Association.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, MS

HEW Will Seek Another Second Opinion

Proving that the bureaucratic mind can't drop an idea no matter how badly it works, the Department of HEW has again announced a campaign to encourage people to get second opinions before surgery.

The program, which apparently will consist of TV commercials by actor Cliff Robertson and other HEW public relation materials, will urge people to get a "second opinion" and give a toll free hot line for patients to call for names of "second opinion physicians."

When the program was initially announced by HEW in the fall of 1978, it received about as much consumer enthusiasm in Mississippi as the FTC's recent ruling that physicians can advertise their services and charges.

At that time MSMA's Board of Trustees pointed out that the idea of consultation among physicians on difficult cases was as old as medicine itself and that HEW's second opinion program would merely confuse the public and increase health care costs. The cost aspect was emphasized by the fact that there are

some 18 million surgical procedures performed annually in this country.

At the same time MSMA's largest component society, Central Medical Society of Jackson, mounted a TV campaign to inform the public that the medical profession had always supported the concept of seeking consultation in difficult cases or when requested by the patient. In spite of this record, HEW in typical fashion decided to mount its second opinion campaign which subsequently fizzled. Apparently another fizzle is now in the offering. — C.L.M.

No Advertising for Doctors

We obviously need doctors. And advertising is certainly the finest medium for passing along information since messenger angels. Particularly newspaper advertising.

But I fear that combining the two will be about as beneficial to the future of civilization as a 100-year, world-wide corn blight.

The federal government, however, seems bent on allowing it, if not actually encouraging it.

It is difficult, of course, to conceive of our government erring, but I'm convinced that is exactly what is happening.

The particular culprit in this case is the Federal Trade Commission.

No doubt officials of that agency thought they were operating in the best interest of the nation a couple of weeks ago when they ordered the American Medical Association to lift its ban on doctors' advertising. But the best laid schemes of mice and bureaucrats often go haywire.

In this particular case, I'm afraid, the hay has gone about as wirey as any that modern civilization has been asked to cope with.

Normally I snicker more than a little bit when so-called professional groups tell me it is beneath their dignity to advertise.

I wonder if lawyers object to having their messages carried in a newspaper because it is thrown unceremoniously onto a doorstep in the wee hours of the morning. Or is it that they prefer not to call attention to themselves on a newspaper page that might also carry an account of a lawyer with his feet in hot water?

And I am a bit surprised that advertising ruffles the ethical consciousness of certified public accountants.

It would be hard to muster fear that grave damage would befall either mankind or the dignity of those professions should they flaunt their services through advertising.

But with doctors I worry.

If I go to one with an acute pain that runs from the top of my head to the farthest reaches of my big toenail, I want to have the upmost confidence in his abilities to handle the situation.

Perhaps I have become spoiled, but I expect certain things from the medical profession.

I expect to be put on hold for two hours in a waiting room.

I expect the doctor to mumble an ummm or two, then speak in language I cannot comprehend.

Those are the type things that give me reassurance.

If my doctor is not busy beyond belief, I wonder why.

If his office is not drab and clinical and if his taste in art extends beyond a print of the internal parts of the human body, I develop serious doubts about his professionalism.

I begin to wonder if, along with decorum in doctoring 1-A, he also flunked acute pain and toenail reaches while in medical school.

If I want flashing neon lights, smiling girls running around in sexy costumes and a cocktail bar adjacent to the waiting room, I'll catch a plane at the Jackson airport.

I realize that the FTC only talked of advertising prices for basic services in an ill-advised effort to reduce medical costs.

But that, I fear, would be only a first step.

The next move would come when advertising agencies begin selling television packages to doctors.

You'll be sitting in your living room some evening and suddenly the programming will switch to a message from a leading pediatrician.

Little kids wearing funny ears will dance across your television screen singing to the tune of Mickey Mouse's song: "D-O-C . . . T-O-R . . . J-O-N-E-S . . . Doctor Jones, Doctor Jones, forever he will treat our measles well."

On another occasion you might be lying in a hospital bed. The nurse will come and give you the shot. Suddenly a surgeon comes on the tube in the room. "My colleague, Dr. Doe," he might say, "promises lower prices on appendectomies. But can you really afford to skimp on surgery?" he'll ask.

That's the last thing you hear as you drift off to sleep while the orderlies wheel you into the operating room.

And guess who your doctor is?

And if you think any of this is farfetched, just look at what television has done to the breakfast food and headache remedy industries.

Something, I believe, is rotten in the state of a Federal Trade Commission that would wish this upon a body politic that other federal agencies have already inflicted with an acute case of ulcers.

The AMA should prescribe a head examination. Or an FTCectomy.

—Reprinted from the
Kosciusko *Star-Herald*

THE LITERATURE

Book Review

Current Surgical Diagnosis and Treatment: 4th Edition. By J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1125 pages, illustrated. Los Altos, CA: Lange Medical Publications, 1979. \$19.00.

This is a soft cover, 1125-page, encyclopedic work. By this I do not mean that it covers every facet of surgery. It falls far short of recent editions of *Surgery* by Christopher. I consulted with an established urologist, ophthalmologist, general surgeon, orthopedist, gynecologist, pediatrician, dermatologist, internist and a general practitioner. All commented that *Surgical Diagnosis and Treatment* is not a how-to reference work. Instead, it calls to mind the *Encyclopedia Britannica* — describing conditions, listing pitfalls, rating methods, reporting statistics, evaluating alternative steps in diagnosis.

It was a valuable, though dull, summary, especially where newer x-ray, lab and chemotherapy procedures are becoming proven adjuncts in surgical diagnosis and treatment. The book is weak in illustrations.

The most surprising conclusion I reached was how very little basic precepts have changed since my student years a quarter of a century ago.

My advice is to buy a new "Christopher" and become good friends with it. Then review the 1979 *Surgical Diagnosis and Treatment* at your hospital library, spending two hours looking it over and another two to six hours reading the chapters that interest you.

RICHARD L. GEORGE, M.D.
Tupelo, MS

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Medico-Legal Brief

Court Bars Release Of HEW List

Proposed publication by HEW of a list of physicians and the amount of Medicare payments they each received in 1977 would be contrary to the Privacy Act, a federal trial court in Florida ruled in issuing a permanent injunction.

The Florida Medical Association and six individual physicians brought a class action suit against HEW to enjoin publication of a list identifying every physician in the United States who treated Medicare beneficiaries in 1977. The list would also include the amount of income each physician received from Medicare that year. The physicians claimed that publication of the list would violate the Freedom of Information Act, the Privacy Act and the right to privacy protected by the First, Fifth and Ninth Amendments to the Constitution.

On April 28, 1978, the trial court issued a temporary restraining order which was extended several times by agreement of the parties to the lawsuit. The court granted the American Medical Association and five individuals permission to intervene the suit. It

MEDICO-LEGAL / Continued

then issued another temporary restraining order and granted a ten-day extension of the order.

Subsequently, on July 11, 1978, while waiting for a memorandum of law to be submitted by HEW, the court issued an unusual writ termed an "ancillary writ of injunction," which restrained disclosure of the list and attempted to retain the court's subject matter jurisdiction over the case. On August 23, 1979, however, the federal appellate court (601 F.2d 199) determined that issuance of the writ was procedurally improper and returned the case to the trial court.

On remand to the trial court for consideration of the merits, the trial court concluded that the proposed disclosure, in an individually identifying manner, of annual amounts of reimbursements to providers of services under the Medicare Act would constitute a clearly unwarranted invasion of personal privacy and was therefore included under Exemption 6 of the

Freedom of Information Act. The court also held that the release of such individually identifying information, without the prior written consent of those individually identified providers, is prohibited by the Privacy Act. If the guidelines and regulations Office of Management and Budget and HEW would otherwise allow such disclosure they are contrary to the Privacy Act and without force and effect.

Therefore the permanent injunction was issued on behalf of all physicians licensed to practice in Florida (whether or not they are members of FMA or AMA) and all other members of the AMA who are not Florida physicians if (1) they are providers of Medicare services within the meaning of the Medicare Act and (2) they would be individually identified by the Secretary in a disclosure of annual Medicare reimbursement amounts. — *Florida Medical Association Inc. v. U.S. Department of Health, Education and Welfare*, Docket No. 78-178-Civ-J-S (D.C., Fla., Oct. 22, 1979)

PRACTICE MANAGEMENT MAILBOX

MSMA receives numerous questions from members concerning various aspects of good practice management. Address your inquiries to Practice Management Mailbox, P.O. Box 5229, Jackson, MS 39216.

Accurate Medical Records

The need for accurate medical records is now recognized as being necessary for more reasons than just an efficient practice. Physicians' records may play an important role in personal injury suits, workmen's compensation hearings and medical malpractice cases.

Depending on how they are kept, medical records can make or break the physician. As members of the Mississippi Medical Fraternal and Educational Society's Claims Committee will verify, the best defense in an action involving the practice of medicine is accurate, complete and legible records. Although record keeping is time consuming, very often boring and may allow less time for patient services, today physicians practice in an environment that requires proper documentation of what they have done.

In the November-December 1979 issue of "Malpractice Digest," Harold L. Hirsh, M.D., J.D., and Jonathan Bromberg, M.S., J.D., noted the "Ten Commandments" for the physician to follow in developing good records. They are:

- (1) Do them promptly.
- (2) Do them yourself.
- (3) Note the date and time of each entry.
- (4) Write legibly.
- (5) Never "edit" an entry, even for legibility.
- (6) If an error is discovered, cross out the inaccurate material with a single line, initial it, note date and time and enter the correction in chronological order. Never alter the record.
- (7) Record relevant facts — avoid vague and ambiguous statements such as "patient is feeling better." Vague and ambiguous entries may later haunt the physician when they are used to suggest poor, irresponsible or unresponsive care.
- (8) Give opinion backed up by facts.
- (9) Derogatory, trivial or loose comments about patients or colleagues should never be recorded. Such comments can prove embarrassing when publicized later and do nothing to improve the physician's position.
- (10) Record accurately.

Accurate medical records have always been one indication of an efficient practice. In today's legal climate accurate records are a necessity for practice. By following a few proven steps physicians can assure that their records will be accurate and that their time is better spent on patient care. — B.C.M.

MEDICAL ORGANIZATION

MSMA Plans Activities as 1980 Legislature Convenes

The 1980 Regular Session of the Mississippi Legislature convened in Jackson Jan. 8 amid building renovations at Central High School, the legislature's headquarters during the remodeling of the Capitol. Although the elevators weren't running and the desks were dusty, it didn't take the lawmakers long to vote themselves an appropriation bill. It also took about as long to discover who was in charge, as the House unanimously re-elected Buddie Newman as Speaker and the Senate acted to strengthen Lt. Governor Dye's position as its presiding officer. Each also got a salary increase from \$15,000 to \$34,000 annually in recognition of their increased duties.

Both Dye and Newman had the opportunity to name many new committee chairmen because of retirements and re-election defeats. Dye was also given authority to name the vice chairmen of all Senate Committees.

MSMA's Emergency Medical Care Unit was a temporary victim of the legislature's move to Central High School. A shortage of space at one time led to discussion of placing the unit in a ladies' powder room. The EMCU has become a popular service with legislators over the years and an opportunity for physicians to see government in action.

As JOURNAL MSMA went to press the association's auxiliary was planning a luncheon for all members of the legislature at the Jackson Downtown Holiday Inn on Feb. 6. Auxiliary members planned to spend the day at the legislature to observe the lawmaking process and to express congratulations and appreciation to their legislators.

MSMA's legislative recommendations for 1980 have been compiled in a brochure and sent to all legislators and members of the association. The recommendations will be introduced in bills from key chairmen and members of the legislative committees which will handle them. Most of MSMA's 1980 legislative recommendations evolved from the "Health Needs Study" chaired by the late Dr. Jack A. Atkinson of Brookhaven and adopted by MSMA's House of Delegates in 1979.

Health legislation before the 1980 Mississippi Legislature is expected to include the annual array of optometry and chiropractic bills. Optometrists an-

nounced during the first week of the session that they would again seek legislation to permit them to place drugs on the eye. Chiropractors announced through the 173-member state chiropractic association that they would seek legislation requiring all insurance companies to pay for their services. A surprise in the chiropractors' announcement was that State Commissioner of Insurance George Dale endorsed their legislation.

MSMA will again distribute the weekly "MSMA Legislative Report" to all members. MSMA's legal counsel, Bucky Murphy, will coordinate the association's legislative program under the guidance of the Council on Legislation. Members of the council are: Charles R. Jenkins, M.D., Laurel, chairman; James W. Rayner, M.D., Oxford; Richard H. Russell, M.D., New Albany; S. Lamar Bailey, M.D., Kosciusko; Robert O. May, M.D., Jackson; Sidney W. Bondurant, M.D., Philadelphia; Walter H. Rose, M.D., Indianola; Walter W. Crawford, M.D., Tylertown; and Dewey H. Lane, Jr., M.D., Pascagoula.

MSMA Board Officers Will Attend Conference

MSMA's Board Chairman, Arthur A. Derrick, Jr. of Durant, Vice Chairman Sidney O. Graves, Jr. of Natchez and Secretary Paul H. Moore of Pascagoula will be among those attending the 1980 AMA National Leadership Conference in Chicago, Feb. 21-24.

Among the speakers at the conference will be Wilbur Cohen, former HEW secretary, who will examine "The Health of the Health Care Industry," and Arnold Weber, Ph.D., economist and provost of Carnegie-Mellon University, who will discuss the nation's economy. The conference banquet program will include a presentation by Michael Korda, bestselling author of "Power! How to Get It, How to Use It" and "Success!."



Murphy Joins MSMA Staff

Burke C. "Bucky" Murphy, who has served as MSMA's legal counsel on a part-time basis since



September 1978, has joined the staff on a full-time basis as assistant executive secretary and legal counsel. He is presently working with the MSMA Council on Legislation in coordinating the association's legislative program. In addition to his duties with other councils and programs of the association, Mr. Mur-

phy will author the new JOURNAL MSMA feature, "Practice Management Mailbox."

A native of Starkville, Murphy received his B.A. from Mississippi State University in 1974 and his J.D. from the University of Mississippi Law School in 1977. He was formerly associated with the Canton law firm of Montgomery, Smith-Vaniz and Stater. He is married to the former Alice Laird of Union.

Mr. Murphy is a member of the Mississippi State Bar Association, the Mississippi Trial Lawyers' Association and Phi Alpha Delta legal fraternity.

KDH Establishes Memorial Tribute to Dr. Atkinson

The Board of Trustees and the medical staff of King's Daughters Hospital in Brookhaven have issued a unanimous directive which honors the memory of the late Dr. Jack A. Atkinson.

The Jack Atkinson Memorial Lecture Series has been established in honor of Dr. Atkinson's "dedicated leadership and ceaseless labors which contributed immeasurably to the advancement of patient care, to Christianity, and to the advancement of the service capability of this hospital and medical community," states the resolution.

Tony Montgomery, executive director of King's Daughters Hospital, stated that Dr. Atkinson, assisted by Dr. Braxter Irby and Dr. Jasper Becker, was instrumental in arranging a very successful continuing medical education seminar for area physicians in April 1979. The memorial lecture series will continue the medical-related education of local physicians, in keeping with the Mississippi State Medical Association's policy of encouraging such programs.

PERSONALS

GEORGE E. ABRAHAM, II, of Vicksburg announces the association of JOHN ROBERT FORD for the practice of family medicine.

ROBERT CURRIER and EDGAR DRAPER of UMC were board examiners for the American Board of Psychiatry and Neurology in Atlanta.

EDWARD C. HAMILTON and JOHN E. WILLIAMS, Gulfport surgeons, have relocated their offices to 1408 44th Avenue.

JAMES D. HARDY of Jackson and UMC presented a paper at a December meeting of the Southern Surgical Association in Hot Springs, VA.

HARPER HELLEMS of Jackson and UMC presented a paper at the VII Asian Pacific Congress of Cardiology in Bangkok, Thailand.

ROY T. HEWSON has opened an office in Senatobia for the general practice of medicine.

JAMES L. HUGHES of Jackson and UMC taught an orthopedics course in Davos, Switzerland in December.

MICHAEL E. JABALEY of Jackson announces the relocation of his office for the practice of hand surgery, plastic and reconstructive surgery to 1417 Lelia Drive.

HERBERT LANGFORD of Jackson and UMC recently lectured at Vanderbilt University, the University of Virginia, Duke University and the University of North Carolina.

PATRICK G. McLAIN of Vicksburg announces the association of JAMES W. COOK for the practice of ophthalmology.

ROBERT O'NEAL and JOE NORMAN, both of UMC, were program participants at the Mississippi Thoracic Society Tri-State Meeting in Biloxi last month.

State Medical Examiner FAYE G. SPRUILL of Jackson was an instructor at a forensic science seminar in Gulfport.

LAMAR WEEMS of Jackson and UMC was speaker for a December meeting of the Prairie Medical Society in Starkville.

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PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

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IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules, 100 gram (3.5 oz.) and 250 gram (8.8 oz.) canisters.



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NEW MEMBERS

ABNEY, RICHARD S., Meridian. Born Bay Springs, MS, June 7, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University of Tennessee Clinical Education Center and Erlanger Hospital, Chattanooga, one year; medicine residency, same, 1977-79; elected by East Mississippi Medical Society.

ARIAS, MANUEL, Meridian. Born Colombia, South America, Sept. 24, 1935; M.D., National University of Colombia Medical School, 1960; interned Chester County Hospital, West Chester, PA, one year; radiology residency, Buffalo, NY and University of Alabama, 1967-69; elected by East Mississippi Medical Society.

BALL, ROBERT MORRIS, Jackson. Born Houston, TX, May 22, 1949; M.D., Duke University School of Medicine, Durham, NC, 1974; interned, same, one year; medicine residency, same, 1976; elected by Central Medical Society.

BROWN, RAYMOND LLOYD, Natchez. Born Unice, LA, May 9, 1935; M.D., Louisiana State University School of Medicine, New Orleans, 1961; interned Doctors Hospital, Shreveport, LA, one year; general practice residency, Lafayette Charity Hospital, LA, 1962-63; radiology residency, Confederate Memorial Medical Center, Shreveport, LA, 1969-72; elected by Homochitto Valley Medical Society.

CAUSEY, WILLIAM A., Jackson. Born Jackson, MS, Aug. 7, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned University Medical Center, Jackson, one year; medicine residency, same, 1969-72; infectious disease residency, University of Chicago Hospital, Chicago, IL, 1974-75; elected by Central Medical Society.

CHEN, CHING, IYGH, Jackson. Born Taiwan, May 30, 1945; M.D., Tazpez Medical College School of Medicine, Taipei, Taiwan, 1970; interned Taipei Veterans General Hospital, Taiwan, one year; ophthalmology residency, same, 1971-75; ophthalmology residency, University of Chicago, 1976-77; ophthalmology residency, Cook County Hospital, Chicago, 1977-79; elected by Central Medical Society.

CROSS, JOHN M., Charleston. Born Paisley, Scotland, Jan. 27, 1928; M.D., University of Alberta Faculty of Medicine, Edmonton, Alberta, Canada, 1962; interned, same, 1962-63; surgery residency,

same 1964; surgery residency, University of Toronto, Canada, 1965-66; surgery residency, University of Saskatchewan College of Medicine, Canada, 1968-70; elected by Clarksdale and Six Counties Medical Society.

FLOOD, JOHN B., Centreville. Born Somerset, KY, Apr. 13, 1931; M.D., Tulane University School of Medicine, New Orleans, LA, 1956; interned Charity Hospital, New Orleans, 1956-57; pathology residency, University Medical Center, Jackson, MS, 1957-63; urology residency, same, 1960-63; elected by Amite-Wilkinson Counties Medical Society.

FORD, WILLIAM R., Jackson. Born Kosciusko, MS, Aug. 18, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and radiology residency, University Medical Center, Jackson, 1973-77; elected by Central Medical Society.

FOUTS, ANTHONY C., Meridian. Born Atlanta, GA, Dec. 14, 1949; M.D., Duke University School of Medicine, Durham, NC, 1975; interned, same, one year; medicine residency, same, 1976-79; anesthesiology residency, same, 1977; elected by East Mississippi Medical Society.

FRAME, DONALD WAYNE, Corinth. Born Blytheville, AR, Mar. 28, 1947; M.D., University of Tennessee College of Medicine, Memphis, 1973; interned Methodist Hospital, Memphis, 1974; radiology residency, same, 1975-77; elected by Northeast Mississippi Medical Society.

GRAVES, GLEN ROBERT, Jackson. Born Parkersburg, VA, Oct. 12, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned, same, one year; pediatric residency, University of Kentucky, Lexington, 1971-72; pediatric residency, University Medical Center, Jackson, 1972-73; elected by Central Medical Society.

GRENFELL, RAYMOND F., JR., Jackson. Born Jackson, MS, Feb. 7, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Cleveland Clinic Hospital, Cleveland, OH, one year; medicine residency, same, 1975-77; endocrinology residency, same, 1977-79; elected by Central Medical Society.

HALBROOK, JOHN C., Tupelo. Born Greenwood, MS, Oct. 11, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned, same, one year; medicine residency, same, 1975-77; oncology fellowship, same, 1977-79; elected by Central Medical Society.

NEW MEMBERS / Continued

HEATH, BOBBY J., Jackson. Born Grenada, MS, Feb. 19, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned Parkland Memorial Hospital, Dallas, TX, one year; surgery residency, University Medical Center, Jackson, 1972-76; thoracic and cardiology surgery, same, 1976-78; elected by Central Medical Society.

JOHNSTON, JAMES HARVEY, III, Jackson. Born Jackson, MS, Dec. 21, 1946; M.D., Tulane University School of Medicine, New Orleans, LA, 1973; interned Mayo Clinic, Rochester, MN, one year; medicine residency, same, 1974-76; gastroenterology residency, UCLA, Los Angeles, 1976-78; elected by Central Medical Society.

MARLEY, BOULDIN A., JR., Clarksdale. Born Clarksdale, MS, Nov. 29, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University of South Alabama, Mobile, one year; ob-gyn residency, same, 1976-79; elected by Clarksdale and Six Counties Medical Society.

NEWCOMB, MARTIN M., Jackson. Born Hattiesburg, MS, Aug. 29, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and medicine residency, same, 1973-76; fellowship, clinical oncology, same 1976-78; elected by Central Medical Society.

PAINE, THOMAS DAVID, Jackson. Born New Orleans, LA, June 22, 1948; M.D., Medical College of Georgia, Augusta, 1973; interned and medicine residency, University of Alabama, Birmingham, 1973-76; cardiology fellowship, same, 1976-78; elected by Central Medical Society.

PHAM, TUAN QUANG, Greenville. Born Hanoi, Vietnam, Aug. 5, 1933; M.D., University Saigon Faculty of Sciences, Vietnam, 1961; interned Duy Tan General Military Hospital, one year; National Military Sanatorium, 1959-61; elected by Delta Medical Society.

PRINGLE, DONALD F., Meridian. Born Belleville, Ontario, Canada, Nov. 2, 1936; M.D., Queen's University Faculty of Medicine, Kingston, Ontario, 1963; interned Montreal General Hospital, one year and Charlotte Memorial Hospital, Charlotte, NC one year; elected by East Mississippi Medical Society.

ROBERTS, ANNE A., Maben. Born Meridian, MS, Mar. 2, 1952; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, Uni-

versity Medical Center, Jackson, one year; elected by Prairie Medical Society.

SHIRLEY, STEPHEN M., New Albany. Born Baldwin, MS, July 23, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and family practice residency, Medical Center University of South Carolina, Charleston, 1975-78; elected by Northeast Mississippi Medical Society.

SULSER, RALPH E., Jackson. Born Vicksburg, MS, May 2, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University Medical Center, Jackson, one year; medicine residency, same, 1975-77; elected by Central Medical Society.

TALMOR, HANOCH, Centreville. Born Salzburg, Austria, Nov. 2, 1946; M.D., Hebrew University-Hadassah Medical School, Jerusalem, Israel, 1974; interned, same, one year; pediatric residency, same, Jan.-June 1974; pediatric residency, Mt. Sinai Hospital, Elmhurst City Hospital, New York, NY 1974; pediatric residency, University of Miami, FL, 1975-76; elected by Amite-Wilkinson Counties Medical Society.

UHRMANN, SUSAN B., Jackson. Born Wilmington, DE, Mar. 14, 1947; M.D., Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, 1973; interned Wilmington Medical Center, DE, one year; neonatology residency, Hershey Medical Center, Hershey, PA, 1976-78; elected by Central Medical Society.

WARD, MICHAEL S., Meridian. Born Cullman, AL, Oct. 14, 1943; M.D., University of Alabama School of Medicine, Birmingham, 1969; interned, same, one year; pediatric residency, Baylor, Houston, TX, 1972-74; elected by East Mississippi Medical Society.

HEW Proposes Health Goals

The Department of Health, Education, and Welfare has proposed a set of national health planning goals calling for large reductions in infant mortality and communicable and other diseases and for improvements in ambulatory care and other community health services.

The goals are contained in the National Guidelines for Health Planning published in the *Federal Register* as a Notice of Proposed Rulemaking. The Guidelines cover three broad areas: health status, health promotion and disease prevention, and access to health care.

HEW is required to set goals under the National Health Planning and Resources Development Act of 1974. The goals are to be used by Health Systems Agencies such as the Mississippi Health Systems Agency, Inc. in developing local health plans and by state agencies in preparing state plans.

Among the goals for improved health status, the Department proposed that the infant mortality rate be reduced to fewer than 12 deaths per 1,000 live births nationally and fewer than 18 deaths per 1,000 live births for any health service area or population group. Currently the infant mortality rate is about 15.1 deaths per 1,000 and has been declining steadily throughout the decade.

Deaths from preventable communicable diseases, currently about 15 per 100,000 persons annually, should be reduced to fewer than 12 per 100,000 throughout the country and in every population group, the Department suggested.

Diseases and deaths preventable by vaccine should be reduced to zero, the Guidelines stated. Diseases cited specifically are diphtheria, pertussis, tetanus, polio, measles, rubella and mumps.

In addition, deaths from accidents and violence should be reduced by at least 16% to fewer than 60 per 100,000 persons nationally. Death rates in the U.S. for suicide and homicide in recent years have been the highest ever recorded.

Noting that over one-third of all suicides and one-half of all homicides are alcohol-related, the Department proposed reducing the incidence and prevalence of alcoholism and related disabilities and deaths by at least 5%.

Medicare Issues Regs on Diagnostic Tests

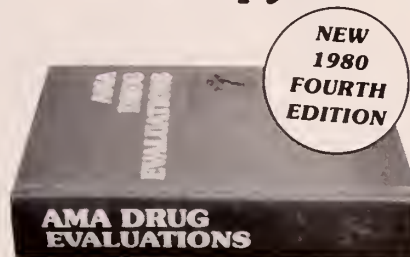
The Health Care Financing Administration has issued Medicare regulations providing that chest x-rays and other diagnostic procedures performed as part of the admitting procedure to a hospital will be covered as reasonable and necessary only when: the test is specifically ordered by a physician responsible for the patient's care; the test is medically necessary for the diagnosis or treatment of the individual patient's condition; and the test does not unnecessarily duplicate the same test recently done on an outpatient or inpatient basis.

The new regulations are expected to apply also to skilled nursing facility admission tests. PSROs will monitor the requirement that diagnostic tests be specifically ordered by a physician responsible for the patient's care.

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Abbott Labs Honors Dr. Preston Herring



Abbott Laboratories of North Chicago, IL, recently honored Dr. Preston S. Herring of Vicksburg for his many years of dedicated medical service to the residents of Vicksburg and Warren County area.

He was presented a Jefferson Gold Hour Clock by Dave Smith, Abbott Labs area professional medical representative.

Dr. Herring, an internal medicine specialist, received his M.D. from Tulane in 1926. He has practiced for more than 50 years, and continues to practice at the Street Clinic in Vicksburg.

Medicaid Reports Fiscal '79 Operations

The Mississippi Medicaid Commission reports it expended \$198,729,437 on 296,461 recipients during fiscal year 1979, an increase of 15% over the \$171,949,077 the program expended on 285,625 recipients in fiscal year 1978.

A review of program expenditures during fiscal year 1979 by type of service (see table) reveals that inpatient hospital and nursing home services accounted for \$122,023,244 (over 60%) of total expenditures. Some 63,519 recipients received inpatient hospital services totaling \$48,559,613 and 14,284 recipients received nursing home care totaling \$73,463,631.

The Mississippi Medicaid Commission, which began as a \$40,000,000 program for some 200,000 recipients in 1970, recently projected an \$11,000,000 deficit in its fiscal 1980 operations. As reported in the January JOURNAL MSMA, the Commission has issued an extensive list of possible benefit reductions should the 1980 Regular Session of the Mississippi Legislature not provide a deficit appropriation.

EXPENDITURES FOR MEDICAL SERVICES BY TYPE OF SERVICE, NUMBER OF RECIPIENTS FOR EACH SERVICE, AND AVERAGE SPENT PER RECIPIENT FOR FISCAL YEAR 1979

<i>Type of Service</i>	<i>Total Expenditures</i>	<i>Number of Recipients</i>	<i>Average Spent per Recipient</i>
Total	\$198,729,437	296,461	\$ 670.34
Inpatient hospital	48,559,613	63,519	764.49
Outpatient hospital	5,957,316	105,614	56.41
Laboratory and x-ray	389,636	22,864	17.04
Skilled nursing home	48,576,135	9,550	5,086.51
Physicians	21,387,102	243,228	87.93
EPSDT ¹	5,631,439	143,348	39.29
Home health	571,571	2,573	222.14
Emergency ambulance ²	343,913	10,151	33.88
Prescribed drugs	27,710,287	245,621	112.82
Dental care	4,420,171	52,165	84.73
Eyeglasses	48,149	637	75.59
Intermediate care facility	24,887,496	4,734	5,257.18
Family planning	1,508,005	27,683	54.47
Buy-In, Part B Medicare (a) ³	5,951,650	60,484	98.40
Buy-In Part B Medicare (b) ⁴	2,786,052	21,023	74.54
Clinic services	902	51	17.69

1. Only persons under 21 years of age are eligible, paid claims, not number of recipients.
2. Number of Ambulance Services paid claims, not number of recipients.
3. Average number of monthly Buy-In premiums paid.
4. Total number of Fiscal 1979 Accretions with back premium charges.

CHAP Is Expected To Pass

The U.S. Senate and House of Representatives are expected to pass a "Child Health Assurance Program" (CHAP) to replace the current Medicaid Early Periodic Screening and Diagnostic Treatment Program in Mississippi and other states.

CHAP will have a significant impact on the Mississippi Medicaid Program. The House-passed bill (HR 4962) is outlined below. Included are parenthetical notations of differences between the House bill and the Senate version of CHAP (S 1204) reported by the Senate Finance Committee. Under the House-passed bill:

Eligibility Standards

CHAP would extend Medicaid coverage to financially eligible children under age 18 (or over 17 up to 21 if the state so opted), and a child meeting the income eligibility standard would be covered regardless of whether such child was a member of an intact family. The income test of Medicaid eligibility for children would be uniform and nationwide (except in a state that opted to cover persons with higher income). The minimum standard of CHAP income eligibility would be two-thirds the official level of poverty; for a family of four this would be about \$5,000 in 1980. (In S 1204 the age of eligibility is set at six or under but, at the option of the state, any child over six and under 21 would be eligible. Financial eligibility would be determined under the state requirements.)

Pregnancy Coverage

Liberalized eligibility standards would also extend Medicaid coverage to financially eligible pregnant women, for prenatal and postnatal care, even though they might be first-time mothers. For a single woman having her first child, the minimum income eligibility level in 1980 would be about \$2,960. (In S 1204 the Medicaid rule — applied in 19 states, but not in Mississippi — that a pregnant woman cannot qualify if she does not already have a dependent child would continue in effect. Financial eligibility would be determined under state requirements.)

States would have an option to provide Medicaid coverage to adopted children who are hard to place

because of a handicapping or medical condition requiring medical care, regardless of the income level of the adopting parents.

Broadened Medicaid benefits for eligible children would be mandated. In addition to current mandatory benefits, required services would include, without limit or co-payment, child health assessments and continuing care, vision and hearing services, immunizations, prescribed drugs, routine dental care, ambulatory mental health services provided in approved clinics, emergency inpatient mental health services, and other specified services. (In S 1204 children who received a timely health assessment would be eligible for all treatment and services which could be paid for under Medicaid, whether or not included in the state plan, but the mandate of expanded services contained in the House bill does not appear.)

Providers

A CHAP provider could be a physician, public health department, HMO health center, school system, or such other as the Secretary specified. Providers agreeing to give basic primary and preventive care to specific children on a continuing basis could be "continuing care providers" and receive reimbursement incentives. (S 1204 makes no provision for a "continuing care" provider.)

CHAP providers would have to enter into agreements with the state to provide services in accordance with standards established by the Secretary. Providers generally would thereby agree to provide timely health assessments and provide or make referral for basic diagnostic and treatment services. The provider would also agree to provide follow-up services or information to the state for such follow-up, manage the medical care for the child, be reasonably accessible, and make reports to the state and the Secretary. A "continuing care" provider would agree, in addition, to provide assessments and continuing care to specific children.

Increased Federal Funds

Each state would receive increased federal matching for health assessments and non-inpatient services to children. The federal share of administrative costs would be increased in states with superior CHAP performance, decreased in states with below minimum level performance.

RECOLLECTIONS

The February 1960 issue of JOURNAL MSMA reported that three MSMA members, Dr. S. E. Field of Centreville, Dr. Harvey F. Garrison, Jr., of Jackson and Dr. Joseph G. McKinnon of Hattiesburg, were appointed to six-year terms on the State Board of Health by Governor J. P. Coleman.

Physicians' fees had been attacked in an article called "Why Doctors Charge So Much" in McCall Corporation's "Redbook" magazine. The author had previously published a controversial book, *The Doctor Business*, which pictured doctors as ghost surgeons, insurance gougers, and fee splitters and which advocated federal medicine and closed panel plans. JOURNAL MSMA noted that paradoxically, the McCall Corporation had a multi-million dollar contract to print the *Journal of the American Medical Association*.

Scientific articles included: "Carcinoma of the Colon in Young People," by Drs. Jack V. King and DeWitt T. Brock of Jackson; "Maternal Mortality in Mississippi During 1957," by Dr. Michael Newton of Jackson; and "Social Security and Medical Care," by Dr. C. D. Taylor, Jr., of Pass Christian.

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FAMILY PRACTITIONER or general practitioner with surgery interest. Free office space. Moving expenses paid. Modern 36-bed hospital with 60-bed extended care facility. Contact: Nick Wilson, Administrator, Quitman County Hospital, Box 330, Marks, MS 38646. Call collect (601) 326-8031.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

ASSOCIATES or physicians interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Situations Wanted

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

IN CONCLUSION

Regulation of physician supply is the objective of the proposed Rhode Island State Health System Plan. The plan calls for a ceiling on the number of non-federal physicians practicing in the state by 1983 as well as ceilings on the number of certain specialists. A Physician Residency Commission would be established to recommend the appropriate number, specialty types and training capacities of residency programs in the state. Under the plan, hospital surgical privileges would be limited to surgeons who are board certified or are pursuing such certification.

For years the dental health of the nation's 33,000,000 physically and mentally handicapped people has been neglected, says a recent report. But improvements are being made by utilizing traveling dental hygienists, more institutional care, "special patient" clinics and the addition of special courses to teach dental students how to care for these patients. Of particular difficulty for dentists have been those patients who are medically compromised with conditions such as diabetes, arthritis, epilepsy, heart conditions and hemophilia.

A device which claims to cure the common cold has been patented in Israel, and is due on the market in three years at an estimated cost of \$200. The "Rhinotherm" produces a stream of wet hot air which the patient inhales for fifteen minutes. In 85% of those tested so far, there was immediate relief from cold symptoms and no recurrence, it has been reported. Allergy sufferers have had relief for up to 15 days after a treatment. Another device, "Footprint," claims to offer a safe way of diagnosing various orthopedic conditions and may eliminate the need for x-ray.

"Malpractice Digest" reminds physicians to chart a patient's noncompliance with instructions to take medicine, return for follow-up care or other failure to follow orders. Noncompliance has reached "disastrous proportions" with as many as two-thirds of all U.S. patients failing to take their medications properly, says a report issued at a recent meeting of the American College of Physicians. Among the worst noncompliers are people with hypertension. Some studies indicate that as many as 90% of patients with high blood pressure fail to take medicine as instructed.

A federal report on technology is an affront to the nation's democratic institutions and makes "improper conclusions on the activities of the scientific community," the AMA told the National Institutes of Health. The report calls for establishment of an advisory commission to evaluate and anticipate the probable effects of research and technological advances. The AMA noted that the cooperation now existing between publicly and privately sponsored scientists and physicians has led to breakthroughs enabling the American patient to receive the most advanced medical care possible.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication, abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given, do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return readminister if necessary, not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures, use topical anesthetic have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypocoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia

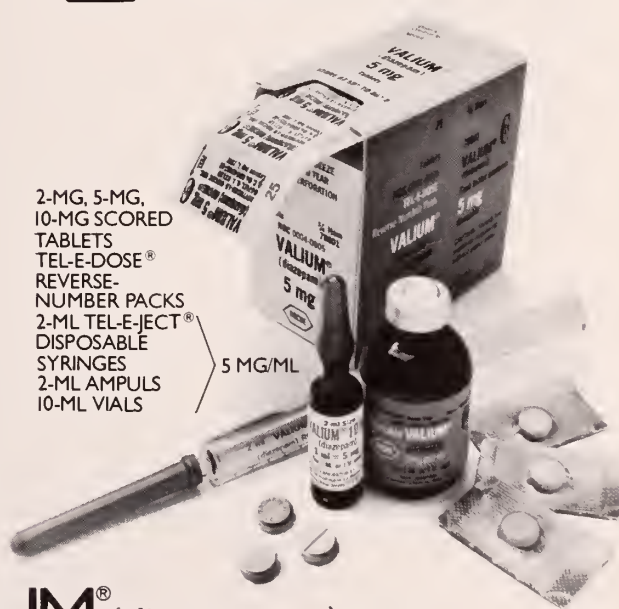
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500, Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10, Vials, 10 ml, boxes of 1, Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative



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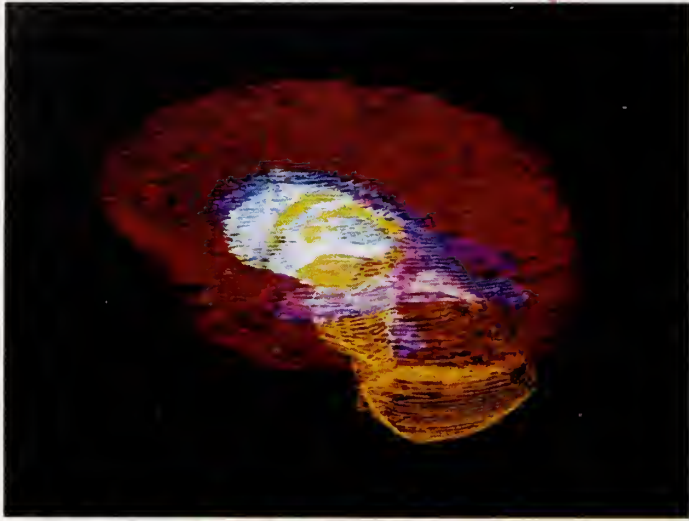
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ROO

March 1980

BALCONY

Journal of the
State Medical
Association

Mississippi

(ISSN 0026-6396)

Contents:

Intraocular Lens
Implantation

Obstructive Jaundice
Secondary
to Carcinoma of the
Gallbladder

National Health
Insurance —
Can We Afford It?



A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium[®] (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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Carter Presents 1981 Health Budget

A \$60.9 billion health budget, featuring modest increases for most HEW health programs during the fiscal year starting next September, has been submitted to Congress by the Administration. This is more than \$5 billion above the current year's level, largely due to increases in the costs of Medicare and Medicaid.

In presenting the HEW budget at a news conference, Secretary Patricia Harris noted that President Carter's total budget "was constructed in the context of overall fiscal restraints, the necessity to curb inflation, and the requirement to meet needs made compelling by international events." The budget included no mention of President Carter's national health plan, but it did assume savings of \$780 million next fiscal year from the controversial hospital cost containment proposal which was defeated in the House last year.

The total HEW budget came to \$222.9 billion, an increase of \$28 billion, with Social Security programs accounting for \$152.8 billion. The Administration asked \$195 million for professional standards review organizations, an increase of \$51 million.

"PSROs are effective in reducing hospital utilization and the cost of care," the budget stated. Funding for the development of health maintenance organizations would be increased by 19%, for a total of \$57.4 million.

The Administration again proposed eliminating capitation grants for medical students and proposed a decrease of \$77 million in nurse education support. At the same time, there would be increased funding for the National Health Service Corps and for the training of primary care physicians. The Public Health Service budget is \$8.5 billion, an increase of \$372 million. Under PHS, the National Institutes of Health budget rose by \$139 million to a total of \$3.6 billion. Other highlights of the PHS budget include a 45% increase for community health centers; a \$14-million increase for maternal and child health programs; a \$25-million increase for health promotion and disease prevention programs of the Center for Disease Control; a \$20-million increase for mental health community and state project grants; and an additional \$15 million for alcohol abuse projects.

The new budget provides \$83.2 million for expanded programs to train primary care physicians. A total of \$93.5 million is provided to support 6,700 health professions students through National Health Service Corps scholarships. Nurse practitioner training programs would receive \$17 million. The budget provides for a liberalization of Medicare-Medicaid home health benefits at a cost of \$23 million. This proposal would eliminate the requirements for three-day prior hospitalization for eligibility.

Administration's NHI Plan Will Include Chiropractic Services

The Administration will amend its NHI proposal to eliminate the requirement that reimbursable chiropractic services can be provided only on referral from physicians. "The initial specifications for the Administration's legislation were altered to provide a definite role for chiropractors," said President Carter's domestic affairs aide, Stuart Eizenstat, in a letter to the American Chiropractic Association in Des Moines, Iowa, three weeks before the Iowa presidential caucuses.

The President's newest position on chiropractic apparently reversed a statement in his budget to Congress last year that "In the absence of scientific evidence that chiropractic services either improve or maintain health . . ." (Medicaid reimbursement should end). Chiropractic was founded in Iowa in the 1800s by an itinerant peddler.

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Volume XXI

Number 3

March 1980



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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CONTENTS

ORIGINAL PAPERS

- Intraocular Lens **45** JAMES W. RAYNER, M.D.
Oxford, MS
Implantation: A Series
Presentation
- Radiologic Seminar CC: **49** HOSHALL S. BARRETT, JR., M.D.
Obstructive Jaundice Gulfport, MS
Secondary to Carcinoma of
the Gallbladder

SPECIAL ARTICLE

- National Health Insurance **51** CHARLES L. MATHEWS
— Can We Afford It? Jackson, MS
(Reprinted from *Synergos*) LON LARSON
Oxford, MS

EDITORIAL

- Political Problem-Solving: **55** W. MONCURE DABNEY, M.D.
Expect More of the Same Crystal Springs, MS

THIS MONTH

- The President Speaking **54** Banquet Night at Annual Session
- Practice Management **56** Terminating the Physician-Patient
Mailbox Relationship
- Medical Organization **57** Council Finalizes Plans for 112th
Annual Session
- Recollections **66** From the March 1961 Issue of
JOURNAL MSMA

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Dr. Hardy Announces Surgical Forum Faculty

Some 300 surgeons from across the United States are expected in Jackson March 13-15 for the University of Mississippi Medical Center's seventh annual surgical forum.

Dr. James D. Hardy, professor of surgery and chairman of the department at the Medical Center, coordinates the annual postgraduate seminar.

UMC faculty members will join internationally recognized guest lecturers in presenting the programs. Medical Center faculty members on the program are Dr. J. Harold Conn, professor of surgery and chief of the Veterans Administration Medical Center surgical service; Dr. James L. Hughes, associate professor of surgery (orthopedics) and chief of the division of orthopedics; Dr. Michael E. Jabaley, clinical professor of surgery (plastic); Dr. Myron W. Lockey, professor of surgery (otolaryngology) and chief of the division of otolaryngology.

Also, Dr. Richard C. Miller, professor of surgery, assistant professor of pediatrics, school of medicine associate dean for clinical affairs and University Hospital medical director; Dr. William A. Neely, professor of surgery, assistant professor of biochemistry, assistant professor of physiology and biophysics; Dr. Norman C. Nelson, professor of surgery and School of Medicine dean; Dr. Dennis O'Callaghan, professor of microbiology; and Dr. Robert R. Smith, professor of neurosurgery and chairman of the department.

Registration fee for the three-day course is \$175. The program carries 17 contact hour credit in Category I of the Physician's Recognition Award of the American Medical Association.

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State St., Jackson, MS 39216.

Tupelo Hosts CME Seminar

"Clinical Management in Acute Respiratory Insufficiency" is the topic of a seminar scheduled for March 27 at the Ramada Inn Convention Center in Tupelo.

Sponsor of the CME session is North Mississippi Medical Center. For more information call 842-3632, ext. 1602.

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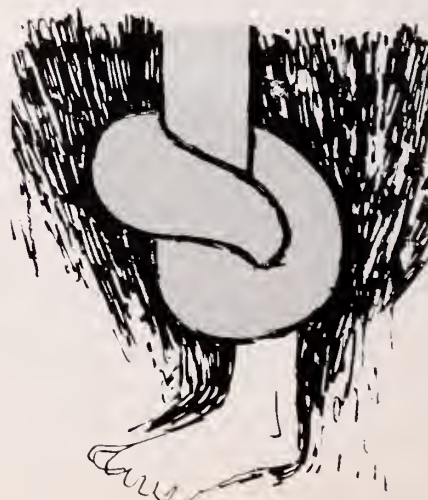
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96th Congress Reconvenes, Studies Health Legislation

Members of Congress returned to Washington January 22 to begin the Second Session of the 96th Congress. A number of pieces of health legislation have work remaining, but in an election year and with foreign crises of preeminent importance, Congress may have little interest in fighting over often controversial health issues, and new initiatives may be few.

Medicare Amendments

Substantial changes to the Medicare/Medicaid programs are still under consideration. HR 3990, the "Medicare Amendments of 1979," was reported out of the Ways and Means Committee Nov. 5, 1979. HR 4000, the "Medicare and Medicaid Amendments of 1979," is under the joint jurisdiction of the Ways and Means and Commerce Committees. Ways and Means also reported this bill out Nov. 5, but the Commerce Health Subcommittee still must finish its consideration of the bill. To date the Commerce Health Subcommittee has agreed to several amendments to the bill. Subcommittee members, however, want to add additional amendments to HR 4000 which would reimburse nurse-midwives; allow HEW to impose a civil monetary penalty for fraudulent claims; and prohibit clinical laboratory percentage contracts. The Commerce Health Subcommittee is scheduled to resume consideration of the bill soon.

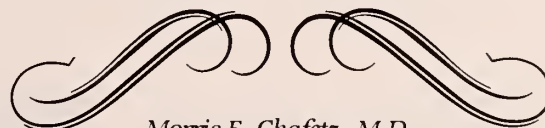
A similar bill, HR 934, was reported out of the Senate Finance Committee Dec. 10, 1979. In addition to including many provisions similar to those in the House bills, HR 934 also contains the Talmadge version of cost containment, although limited in scope to just the Medicare/Medicaid programs. HR 934 may become the vehicle for the Administration to attempt to revive its hospital cost containment proposal. Senate floor consideration of this bill is expected early in 1980.

CHAP

Another major piece of legislation awaiting final Congressional action is HR 4962, the Child Health Assurance Act. The House passed this bill Dec. 11. The Senate companion bill, S 1204, was reported out of the Senate Finance Committee on July 30, 1979. However, the bill is being held for possible inclusion as part of the catastrophic health insurance proposal which Long wants reported out of Committee and passed this year. Substantial differences between the House and Senate bills make passage of CHAP doubtful.

It is doubtful there will be another independent cost containment bill pushed in the Second Session, but some form of cost controls may be included in the catastrophic health insurance bill, if one is reported out of the Finance Committee. Washington sources indicate there will be a continuation of pro-competition proposals regarding reimbursement of health care providers. These are also intended to reduce health care costs. One of the most prominent of these proposals is HR 5740, the "Health Cost Restraint Act of 1979," sponsored by Representative Al Ullman (D-Ore.), Chairman of the Ways and Means Committee. In the Senate S 1590, the "Comprehensive Health Care Reform Act," sponsored by retiring Senator Richard Schweiker (R-Pa.), and S 1968, the "Health Incentives Reform Act of 1979," sponsored by Senator David Durenberger (R-Minn.), may receive more attention.

The Senate Finance Health Subcommittee held a number of markup sessions on catastrophic health insurance proposals late in the last session of Congress. The Subcommittee has reached consensus on



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CONGRESS / Continued

a number of provisions. Senator Long plans to hold additional markups on catastrophic health insurance early in this session of Congress.

The Ways and Means and House Commerce Health Subcommittees held one day of hearings on HR 5191, the "Health Care for All Americans Act" (Kennedy-Waxman), and HR 5400, the "National Health Plan" (Carter-Rangel), in the last session of Congress, and the fate of these two bills seems tied to the political fortunes of their main sponsors, Senator Kennedy and President Carter.

No major change in the composition of the House Ways and Means and Senate Labor and Human Resources and Finance Health Subcommittees is expected. If the House of Representatives forms a new energy committee, the composition of the House Commerce Health Subcommittee could be affected because several members of the Commerce Health Subcommittee also serve on the Commerce Subcommittee on Energy and Power, and would be logical candidates to sit on a newly formed energy committee.

The principal HEW initiative expected in 1980 will be health manpower legislation. The current

health manpower law expires on Sept. 30. However, reliable Washington sources indicate that HEW is still months away from having its proposal ready. Also, there is some feeling in HEW and on Capitol Hill that Congress, in an election year, would not give a comprehensive manpower revision bill its detailed attention. A 50-50 chance exists, therefore, that HEW may settle for a simple one-year extension of the current law.

Manpower Objectives

Reliable Washington sources indicate that if HEW does submit a comprehensive manpower bill, it will be structured around four major objectives: (1) to remove incentives for unwarranted growth in aggregate supply of health professionals; (2) to promote growth in the supply of primary care health professionals; (3) to assure the availability of health professionals in underserved areas; and (4) to increase minority participation in the health professions.

Another proposal likely to occupy a significant amount of HEW's time in 1980 is the implementation of the recently enacted health planning law (PL 96-79). HEW must also react to the public comments on the National Health Planning Guidelines, which were issued in draft form in October 1979. These goals will have to be modified, according to Washington sources, because they do not reflect the intent of the new law.

HEW will continue work in 1980 on uniform Medicare and Medicaid procedure terminology. Finally, there is the possibility that HEW may move to develop statewide fee schedules for these programs.

Professional Standards Review Organizations (PSROs) are in better budget shape this year and the Administration may move to have PSROs expand their review activities. Continued activity is expected in the development of uniform hospital data reporting and collecting.

Although surprises are always possible, it is doubtful that the Congress will take on any additional controversial legislation in 1980. This is not only because of the desire of legislators for long weekends and an early adjournment of Congress to facilitate political campaigning, but also because of the very real possibility that Congress may have to spend more time dealing with the foreign crises in Iran and Afghanistan.

(Editor's Note: This overview of health legislation before the Second Session of the 96th Congress was prepared by the AMA and published in "Legislative Roundup.")

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NEWSLETTER

March 1980

Dear Doctor:

One of the highlights of the 112th Annual Session will be MSMA's membership banquet, scheduled for Wednesday, April 30. Featured speaker will be Howard K. Smith, noted ABC news commentator. Prior to his affiliation with ABC in 1961, Mr. Smith had been with CBS News for 20 years. In 1975 he became the only newsman ever to address the House of Representatives when he was chosen to deliver the Flag Day speech as a Special Congressional Honoree for his contributions to American journalism.

Mr. Smith has won numerous awards, including an Emmy, six Overseas Press Club Awards, the University of Missouri Honor Award for Distinguished Service in Journalism. In 1961, he became the first working journalist to win the Paul White Memorial Award, until then given only to U.S. Presidents and one network president.

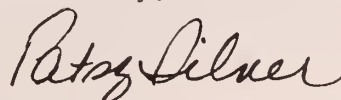
The appearance by Howard K. Smith during Annual Session is being sponsored by the First Mississippi National Bank. This month's "President's Page" message by Dr. Gable expressed appreciation to the bank's Chairman of the Board, Mr. Paul W. McMullan, on behalf of the membership. Tickets to the event are being sold by members of MSMA's Auxiliary.

The collective expense of minor medical tests and procedures affects the annual growth of medical costs more than such technologies as CT scanning, a study by the Robert Wood Johnson Foundation showed. The study concluded that reducing the annual operating costs of the nation's four most complex technologies by half would produce a net savings of less than 1% of 1978 health expenditures.

A book called The Best Doctors in the U.S.: A Guide to the Finest Specialists, Hospitals and Health Care Centers "contains little or no information of practical value," said Dr. William R. Barclay, editor of JAMA, in a recent book review. Dr. Barclay pointed out that although probably everyone listed is a good physician, many good physicians are not listed. He advises consulting local medical societies.

The rate of increase in physicians' fees was 0.7% in December 1979, according to the CPI. The rate of increase for all items in the index was 1.1%, and the rate of increase for all services was 1.3%. Hospital room charges increased 1.1%, and dental services rose 1.7%. December was the fifth consecutive month in which MDs' fees rose at a lower rate than the all items and all services components of the CPI.

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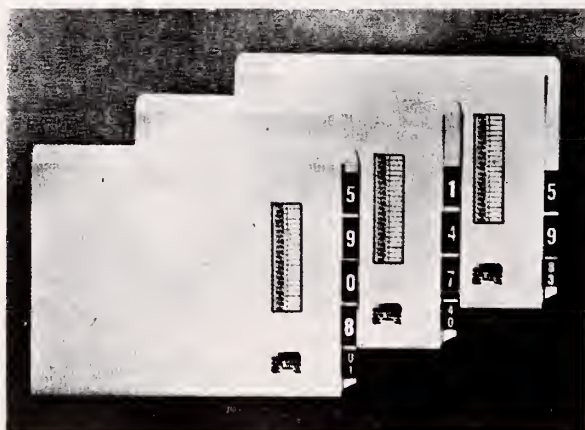
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UM Alumnus Gives Med Center Valuable Mining Claims

An Ole Miss alumnus has given the University of Mississippi Medical Center a one-third interest in some 200 Montana mining claims. The claims were appraised at \$4.3 million last November before silver prices began to climb.

Dr. Julius Levine of Hayward, CA, earmarked the gift, made through the University of Mississippi Foundation, for a continuing education building on the Medical Center campus in Jackson and for medical research programs. All the claims, valued at \$13 million last fall, will be deeded to the Medical Center in one-third parcels at five-year intervals.

Longterm income from the mine could make Dr. Levine's gift one of the largest single contributions ever made to an American institution of higher learning.

The mines included in the gift are located in the heart of the Rocky Mountains about 20 miles from the Continental Divide. According to Velon Minshew, director of the Mississippi Mineral Resources Institute on the Oxford campus, the land is of great scientific interest. In addition to silver, the holdings contain copper, gold, lead and other ores.

"Dr. Levine is an extraordinarily generous man," said University of Mississippi Chancellor Porter L. Fortune, Jr. "Few individuals have provided such open-handed support for medical education and research, and we are indeed grateful to this outstanding alumnus."

Dr. Norman C. Nelson, UMC vice chancellor, said Dr. Levine's gift "will have enormous impact on health care in Mississippi — in this and future generations. This is just the latest demonstration of Dr. Levine's long-time support."

Dr. Levine, a California ophthalmologist, attended Ole Miss from 1928-1933 and received a certificate from the two-year medical school on the Oxford campus in 1935. He finished his medical training at the University of Arkansas, where he received the M.D. in 1937. His daughter Susan is a medical student at the Mississippi Medical Center.

Further details about the continuing education facility will be announced at Continuing Education Day in April. The event is sponsored by the Guardian Society of the Medical Alumni Chapter of the University of Mississippi Alumni Association and will celebrate the Medical Center's 25 years of service to the state.

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- Strengthens stimulus to defecate by increasing indigestible residue
- Helps produce soft, hydrated, well formed stool



A unique granular formulation

- No mixing or chewing
- Granules are placed in mouth and swallowed with full glass of beverage
- Helps break cothortic habituation
- Helps establish normal defecatory reflexes and regular bowel rhythm

Senna

- Produces mild peristaltic stimulation
- Helps propel bulk through colon

John Moerz, M.D.
Medical Director
W. H. Rorer, Inc.
Fort Washington, PA 19034

Dear Dr. Moerz:

Yes, I would like to receive a supply of Perdiem™
starter samples for my patients.

Dr. _____

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Zip _____

Specialty _____

New Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydracallid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours); reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules; 100 gram (3.5 oz.) and 250 gram (8.8 oz.) canisters.



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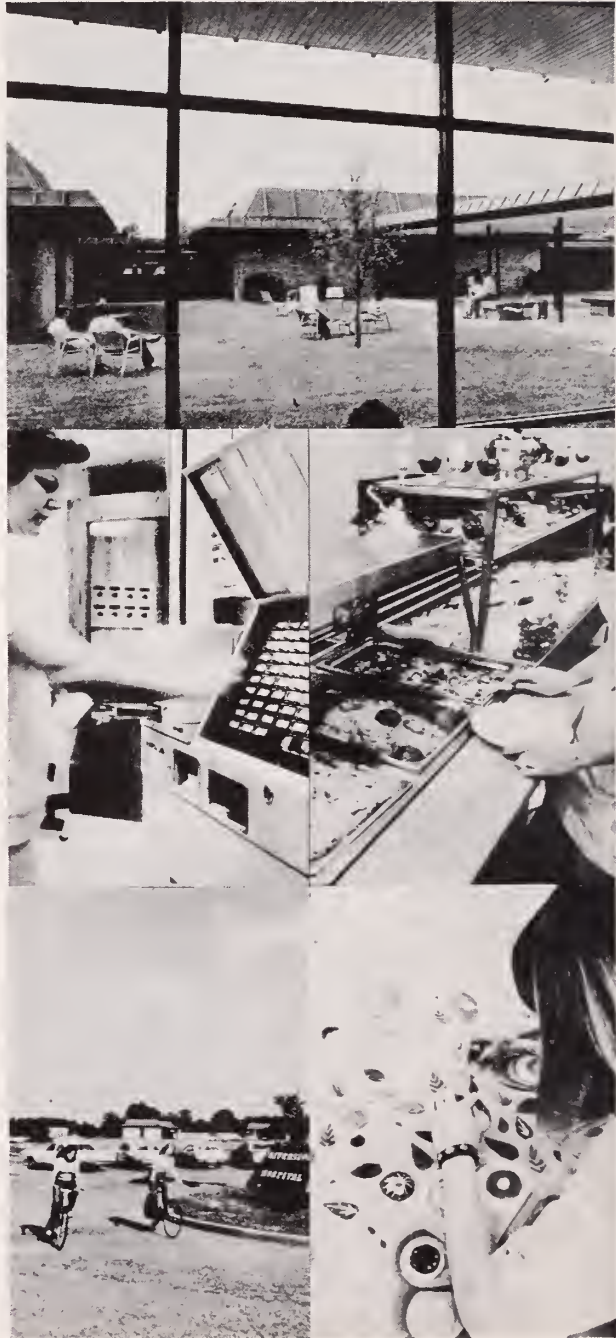
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

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Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.

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DATELINE

AMA Urges
Federal Probe

Chicago, IL - The AMA has called for a federal re-evaluation of policies on community health centers and the National Health Service Corps. In a letter to the House Committee on Appropriations, chaired by Mississippi Congressman Jamie Whitten, the AMA pointed out that the increasingly costly programs have been operating for years without fulfilling the promises of the law. The association called for a closer look at funding of community health centers and defining manpower shortage areas.

Dengue Fever
Alert Issued

Jackson, MS - Mississippi residents have been warned by the State Board of Health to be on the alert for dengue fever this summer, as the mosquito-spread disease moves northward from Mexico. Dr. Durward Blakey, Director of the Bureau of Disease Control, has cautioned physicians that the state presents a highly susceptible population, since dengue has not been present since 1945. He urges active surveillance and prompt reporting of suspect cases to improve control efforts.

Variations Found
In Generic Thyroid

Chicago, IL - Generic thyroid replacement preparations are not always equal, and the individual using the generic substitute may be getting an improper dosage, said a Harvard Medical School report in a recent issue of JAMA. Wide variations in thyroid content have been found, causing Dr. Robert W. Rees-Jones to suggest that appropriate guidelines for hormonal content of thyroid replacement preparations be established, to insure that patients receive the needed or expected dosage.

HSA Projects Need
Local Input

Washington, DC - A memorandum from Dr. George I. Lythcott, Assistant Surgeon General, to all regional health administrators states that "applicants for HSA projects must inform physicians and dentists practicing in the area of the intent to develop a project and invite suggestions and support they may be able to provide, in addition to contacting organized medical and dental societies..." Directive affects community health centers, RHI programs and placement of National Health Service Corps doctors.

Nursing Shortage
Continues

Jackson, MS - The nursing shortage in the tri-county region around Jackson continues and is showing evidence of widening to other areas, according to recent news reports. Local hospitals report that auxiliary staff is being used more extensively under guidance of RNs and that part-time help is being sought. The possibility of higher salaries elsewhere and the decision by many nurses to go into research or specialty fields have been indentified as causes for the shortage.

UMC Schedules Oncology Symposium

A University of Mississippi Medical Center symposium on March 21-22 will outline recent advances in oncology.

Dr. J. Tate Thigpen, UMC associate professor of medicine and oncology division director, is coordinating the program. Sessions will be at the Holiday Inn North.

"This is the second in a series of programs designed to help the physician manage extensive new developments in the evaluation and treatment of patients with neoplastic diseases," program planners say.

Sessions include recent developments in breast carcinoma, the role of newer radiation techniques in cancer management, management of ovarian adenocarcinoma and clinical utility of tumor markers.

The program is sponsored by the University of Mississippi School of Medicine and the Medical Center Division of Continuing Health Professional Education, with support from the Dameron Friley Spruill and Wilma Zay Spruill Memorial Lecture in Oncology and Roche Laboratories.

Guest faculty for the program are Dr. James Arse-

neau, associate professor of medicine in oncology at the University of Rochester Cancer Center and head of medical oncology, Rochester General Hospital; Dr. Philip DiSaia, professor and chairman of the department of obstetrics and gynecology, University of California at Irvine College of Medicine; and Dr. Henry M. Keys, clinical director of the Division of Radiation Oncology at the University of Rochester.

UMC faculty members on the program are Dr. Lodovico Balducci, assistant professor of medicine and on the medical service (oncology) at the VA Medical Center; Dr. Joe C. Files, assistant professor of medicine; Dr. William J. Gibson, clinical instructor in surgery; Dr. Francis S. Morrison, professor of medicine and director of the Division of Hematology; Dr. Spencer L. Schreiter, assistant professor of medicine; and Dr. Ralph Vance, assistant professor of medicine.

Registration fee for the program and a dinner on March 21 is \$40. The course carries eight contact hours credit in Category I of the Physician's Recognition Award of the American Medical Association. American Academy of Family Physicians credit has been applied for.

Contact the Division of Continuing Health Professional Education at the Medical Center for more information.

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Physician Protests Nuclear Proliferation

Dr. Thomas Wesson, Sr., of Tupelo addressed a rally of anti-nuclear demonstrators in Chattanooga recently, and vowed he will do all he can to fight nuclear proliferation.

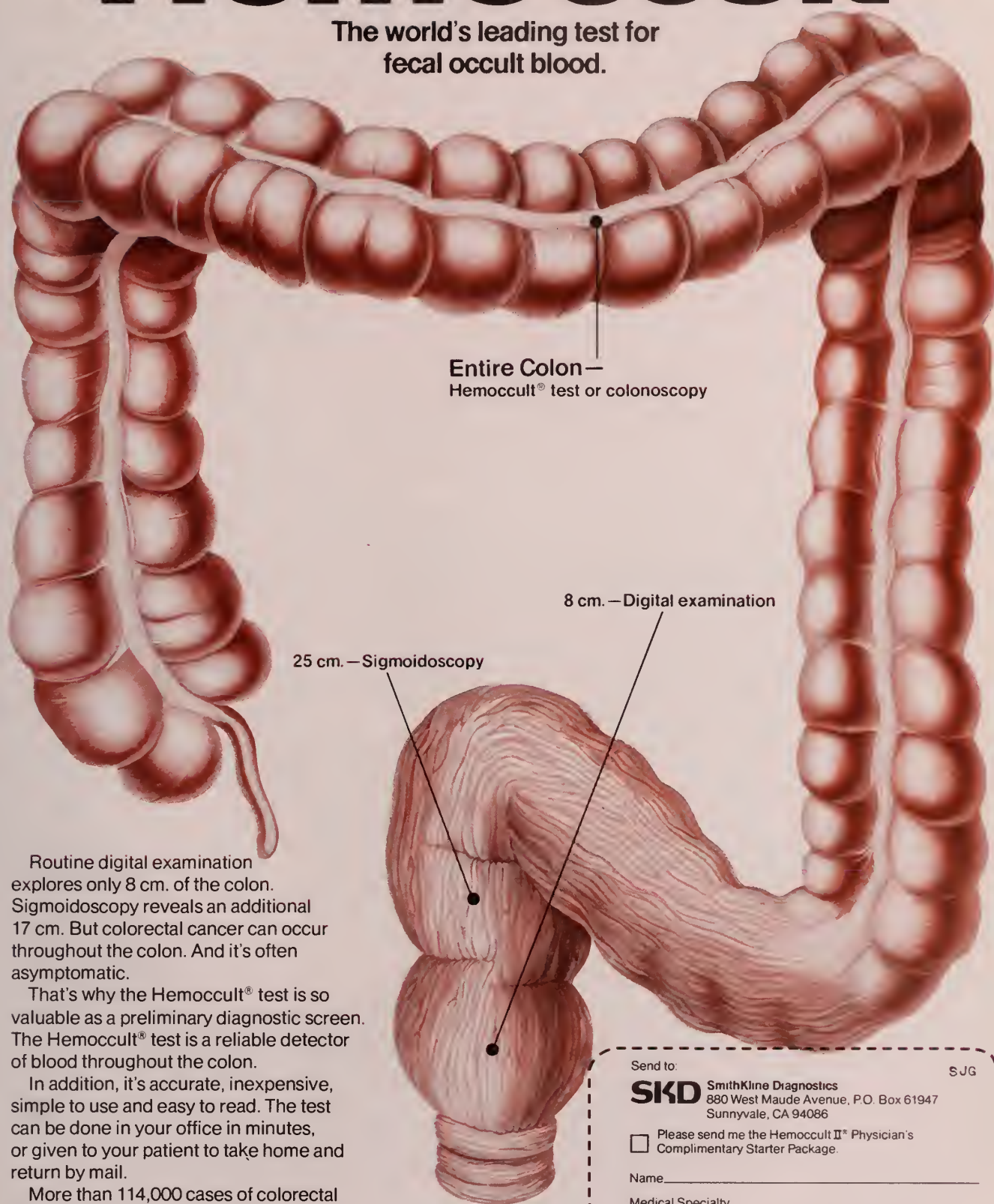
The group had assembled to protest the Tennessee Valley Authority's Sequoyah nuclear plant. Dr. Wesson told the group that people risk cancer and death from inhaling plutonium particles, and noted that some 400 to 500 pounds of plutonium are produced each year by a single nuclear reactor. "The safe storage of this material has not been worked out," he said.

Dr. Wesson remarked that the damage to a person's lungs from plutonium particles would be caused over a period of 10 to 20 years, and he stated that there is no way to detect the presence of these particles.

Dr. Ellis Perry of Corinth accompanied Dr. Wesson to the meeting. Both are members of a group called Physicians for Social Responsibility.

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The world's leading test for
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Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult[®] test is so valuable as a preliminary diagnostic screen. The Hemoccult[®] test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 114,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult[®] starter package, today.

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**When painful spasm
is the presenting
symptom...**



...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

Bentyl[®]

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia, increased ocular tension, loss of taste; headache, nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: Adults: 1 tablet three or four times daily. Bentyl Injection: Adults: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

AMA Membership Increases

AMA membership for 1979 was 223,000, an increase of 12,700 over the 1978 figure. In 1979 the AMA had 192,100 dues-paying members and 30,900 dues-exempt members. Of the dues-paying total, 151,600 were regular members, 20,300 were interns and residents, and 20,200 were students. All membership goals were exceeded last year, with regular members numbering 3,900 more than in 1978 and resident and student membership increasing 8,800 over 1978.

"We're encouraged with this kind of progress," said AMA Executive Vice President James H. Sammons, M.D., "but we certainly can't be satisfied with the gains. The number of full dues-paying members is not rising proportionately with the physician population. Too many physicians are content to take a free ride and let their colleagues pay all the costs of national leadership."

CE Day Plans Are Announced

Dr. Arthur C. Guyton, chairman of the department of physiology and biophysics at the University of Mississippi Medical Center, will present the keynote address during the UMC School of Medicine's portion of Continuing Education Day at the Medical Center April 19.

Other UMC faculty members on the School of Medicine continuing education program are Dr. James D. Hardy, professor of surgery and chairman of the department, and Dr. Harper K. Hellems, professor of medicine and chairman of the department.

Continuing Education Day is sponsored by the Guardian Society of the Medical Alumni Chapter of the University of Mississippi Alumni Association. Alumni of the Schools of Nursing, Health Related Professions and Dentistry are also planning continuing education programs in their disciplines during the day.

The Hon. J. P. Coleman, chief justice of the fifth circuit court district, will address UMC alumni at a dinner that evening at the Holiday Inn Downtown.

The Guardian Society will honor 13 Mississippians who were in leadership positions during the Medical Center's formative years during the April 19 dinner.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

IT WAS
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AND IT STILL IS...

The professional source of
modern anorectal comfort

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C). Full information is available on request.

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V-Cillin K[®]

penicillin V potassium

is the most
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brand of oral penicillin



Tablets
125, 250, and 500 mg*
Oral Solution
125 and 250 mg*/5 ml

V-Cillin K[®]
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies

before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

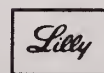
Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

(102175)

***Equivalent to penicillin V.**

Additional information available to the profession on request.



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ORIGINAL PAPERS

Intraocular Lens Implantation: A Series Presentation

JAMES W. RAYNER, M.D.

Oxford, Mississippi

THE FIRST intraocular lens was implanted by Harold Ridley¹ of England in 1949. This type of lens proved to be too large and too heavy. Binkhorst² developed an iris clip lens in 1957 that had four loops, two behind and two in front of the iris. The two superior loops were sutured to each other through the iridectomy. In 1965 he developed a lens with only two loops, both of which were placed behind the iris for capsular fixation following extracapsular surgery. Worst³ developed other iris-supported lenses. Numerous other lens designs have since been introduced.

The majority of lens implantations in the United States have taken place in the past five years. There are patients living in Europe who had lens implants placed in their eyes more than 20 years ago. A longer follow-up is not available, and as a part of informed consent, this is always made very clear to patients contemplating implant surgery.

The major disadvantage to intraocular lens implantation is that it is technically more complicated than a routine cataract operation, and a greater chance for postoperative complications exists because of the presence of the implant inside the eye. Complications that might occur postoperatively in routine operations would simply be more serious, and would require a closer follow-up. The rate of complications varies with the skill of the surgeon. If a meticulous microsurgical operation is performed by an experienced implant surgeon, and if good fixation of the implant — either to the iris or the

capsule — is obtained, then the complication rate should not be significantly different from routine cataract surgery.

This series presentation is designed to provide the non-ophthalmologist with some basic information about intraocular lens implantation — the indications, contraindications, advantages, disadvantages, complications and visual results that may be obtained. The author compares this method of visual rehabilitation of the cataract patient with other methods of visual rehabilitation.

The FDA is now conducting a study of intraocular implant surgery. More than 270,000 patients in the United States have had implantation of lenses since this study began in March 1978. A good deal of controversy centers around a particular type of lens implant known as an anterior chamber lens. I have no personal experience with this type of implant, but news stories about problems and complications of intraocular lenses are frequently associated with the anterior chamber implant. Unfortunately, all types of implant lenses suffer from the bad publicity directed at any particular lens. Another reason for a reported high rate of complications is due to the limited experience of some physicians implanting lenses.

The ideal candidate for intraocular lens implantation is the elderly patient with a monocular cataract. Although some surgeons implant lenses in pediatric and young adult patients, I have confined implant

Dr. Rayner is a practicing ophthalmologist in Oxford, MS.

INTRAOCULAR LENS / Rayner

surgery to patients over 50 years of age, with the majority over 70 years of age. With present techniques and excellent quality lenses, there are very few patients in this age group in which lenses are contraindicated. Most implant surgeons agree that patients with the following conditions should not have implantation of intraocular lens: uncontrolled glaucoma, ocular inflammatory disease, one eye, advanced diabetic retinopathy, myopia greater than 5 diopters, or peripheral retinal pathology.

Method

This paper presents the results of 328 consecutive patients who underwent implantation of intraocular lenses at the time of cataract surgery. This study starts with the beginning of the FDA study on intraocular lenses in March 1978, and ends October 31, 1979. Follow-up ranged from 3 months to 22 months. The total number of patients undergoing the surgery during this time was 333, but five were omitted because of inadequate follow-up (four patients expired one to three months later; one failed to return to the office due to a fractured hip, but her family reports that she "sees well").

Two different types of intraocular lenses were used during this time. Iris-supported lenses were used in 17 cases (5.2%), usually after intracapsular surgery, and capsular-supported lenses were used in 311 cases (94.8%), following extracapsular surgery. Figure 1 shows an eye with a two-loop capsular-supported intraocular implant in place. These lenses were of either polypropylene or supramid loops. The earlier metal loop lenses have been associated with



Figure 1. Eye with two-loop capsular fixated intraocular implant in place.

TABLE 1
PATIENT POPULATION ACCORDING TO AGE GROUP

Age (Years)	Number	Percentage of Total Cases
50-54	4	1.2
55-59	10	3.1
60-64	23	7.0
65-69	65	19.8
70-74	91	27.8
75-79	58	17.7
80-84	45	13.7
85-89	28	8.5
90-94	4	1.2

Average age \bar{x} 73.43.

more complications and were discontinued approximately 2½ years ago.

The majority of patients in this series were over 70 years old with an average age of 73.4 (see Table 1). For patients between 50 and 60 years old (4.3% in this series), special consideration was given to their individual needs. No implants were done on patients less than 50 years old.

Patients were admitted to the hospital in the morning and surgery was performed that afternoon. All operations were done under local anesthesia using marcaine and xylocaine after minimal preoperative sedation. The operating microscope was employed in all cases, and permanent 9-0 nylon sutures were used to insure a permanently tight wound. Extracapsular operations were performed in 95% of the cases, thus requiring a much smaller incision. Approximately 80% of the patients never experienced any postoperative pain.

Generally, patients are allowed full ambulation on the first postoperative day and are discharged on the second postoperative day. The only postoperative restriction placed on patients is to avoid heavy lifting. Patients who live alone are allowed to go home alone and completely care for themselves as they did before surgery. They are permitted immediate use of the eye. They are followed with office visits, and glasses are changed anywhere from two weeks to eight weeks postoperative depending upon the patients' needs and desires.

In extracapsular surgery the cataract capsule is left in the eye and used to insure fixation of the implant. This results in a very stable, fixated and non-moving implant; however, postoperatively the capsule may become hazy, requiring a discission. All discissions in this series were done in the office on a routine return visit, using either topical or local anesthesia. No restrictions whatsoever are placed on physical exertion after this minor procedure.

Results

The obvious objective of cataract surgery is to improve vision. As indicated in the data contained in Table 2, 94% of patients in this series obtained 20/40 or better vision, and 88.8% obtained 20/30 or better vision.

When all patients with preexisting ocular disease that directly accounted for their poor postoperative vision were excluded, 99.47% achieved 20/40 or better vision, with only two patients (0.6%) in the

TABLE 2
RESULTS OF VISUAL ACUITY

<i>Postoperative Vision</i>	<i>Number of Implants</i>	<i>Percentage</i>
20/20	130	39.7
20/25	99	29.9
20/30	63	19.2
20/40	16	5.2
20/50	6	1.8
20/60	5	1.5
20/70	1	.3
20/80	1	0.3
20/100	0	0
20/200	5	1.5
Counting fingers	2	0.6

TABLE 3
PREOPERATIVE OCULAR DISEASE

<i>Disease</i>	<i>Number of Patients</i>
Senile macula degeneration	32
Glaucoma	15
Amblyopia	5
Significant corneal guttata	9
Corneal scar	2
Fingerprint dystrophy	3
Herpes Zoster keratitis	1
Optic atrophy	1

entire series achieving less than 20/40 vision. One of these patients had counting fingers preoperative vision and 20/50 postoperative vision, probably from a poor subjective refraction. Vision of the other patient, an 88-year-old woman, was 20/70 preoperatively and 20/60 postoperatively due to cystoid macula edema.

The associated preoperative ocular diseases are shown in Table 3. Of interest is the fact that 9.8% of these patients had preexisting senile macula degeneration (SMD) of varying degrees. This, however, represents 70% of the patients who did not obtain 20/40 or better vision (see Table 4). Although using intraocular lenses in patients with SMD obviously results in a smaller percentage of patients obtaining excellent vision, SMD is a prime indication for intraocular lenses. Following cataract surgery without lens implantation, the postoperative cataract glasses greatly reduce peripheral vision. Since patients with advanced SMD have central scotomas, they have neither central nor peripheral vision with cataract spectacles. However, with lens implantation they function quite well with the peripheral vision afforded by the intraocular lens. These patients, although with poor vision, are some of the most grateful in the whole series.

The postoperative complications (see Table 5) did not result in worsening of preoperative vision for any patient. In one of the two cases of cystoid macula edema, the patient had 20/60 vision postoperatively and 20/70 preoperatively. In the other case the patient's preoperative vision was counting fingers, and even with cystoid macula edema his final postoperative vision was 20/40. In the five eyes (four patients) with lens dislocation, two occurred in the same patient; but after the implant was repositioned, she obtained 20/20 vision in each eye. Two other patients just required repositioning of the intraocular lens, with resulting 20/20 vision. The fourth patient had chronic dislocation, and the implant had to be

TABLE 4
CONDITIONS RESPONSIBLE FOR FAILURE TO ACHIEVE 20/40 POSTOPERATIVE VISION

	<i>Number of Patients</i>	<i>Post-Operative Vision Range</i>
<i>Pre-operative Conditions</i>		
Macula degeneration	14	20/50 to counting fingers
Amblyopia	2	20/50 and counting fingers
Fingerprint dystrophy	1	20/50
Optic atrophy	1	20/200
<i>Postoperative Complications</i>		
Cystoid macula edema	1	20/60
Poor subjective refraction	1	20/50
Total	20	

INTRAOCULAR LENS / Rayner

sutured to the iris superiorly and later had to be sutured to the iris inferiorly. This patient has 20/30 vision. No dislocations have occurred since the abandonment of early dilatation of the pupil. No other complication has resulted in any vision loss.

TABLE 5
POSTOPERATIVE COMPLICATIONS

Complication	Number of Patients
Hyphema	0
Secondary glaucoma (transient)	4
Cystoid macula edema (persistent)	2
Retinal detachment	0
Endophthalmitis	0
Lens dislocation	5
Acute corneal decompensation	0
Flat anterior chamber	0
Persistent uveitis	0

Discussion

The complication rate in this series and in other large series reported by other authors⁴⁻⁵ (with the exception of a reduced rate of retinal detachment in implant series) is not significantly different from routine cataract surgery. Ophthalmologists generally agree that 20/50 to 20/60 phakic vision (before cataract surgery) is desirable to 20/20 aphakic vision (with cataract glasses). Pseudophakic vision (with lens implant) is comparable to phakic vision; therefore, even if patients only attained 20/50 vision following implant surgery, most would be happier than patients with 20/20 vision and cataract glasses.

Comparison of the results of the two types of surgery must also include quality of vision and patient satisfaction. In my experience, the optical ben-

efits or improved quality of vision to the patient are tremendous with an intraocular lens as compared to spectacle cataract glasses. Tables that show final visual acuities and other data in no way can explain the maladjustment and unhappiness of elderly patients who are suddenly thrust into a magnified (25% to 30%) and partially distorted world with limited peripheral vision as seen through aphakic spectacles. Although the postoperative wearing of contact lenses eliminates these problems, there are only a limited number of elderly patients who can adequately manage contact lenses. The continuous wear contact lenses have the potential of eliminating these problems, but only a limited number of patients can wear these successfully, as well. My personal experience has been disappointing in a significant number of cases. It is also of interest that of my patients who wear a contact lens on one eye and have a lens implant in the other eye, almost all have requested that an implant be placed in the eye with the contact lens.

Although implant surgery remains controversial, particularly among ophthalmologists who do not do implant lenses, one would have an extremely difficult time convincing these patients that there is a better means of restoring vision, when cataract surgery is necessary. ★★★

512 Van Buren Avenue (38655)

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Radiologic Seminar CC: Obstructive Jaundice Secondary to Carcinoma of the Gallbladder

HOSHALL S. BARRETT, JR., M.D.

Gulfport, Mississippi

ULTRASOUND and computerized tomography are valuable tools in diagnosing obstruction to the major outflow of the biliary tract and frequently suggest the etiology of obstructive jaundice. This report describes such a case. In this patient with obstructive jaundice, ultrasound and computerized tomography demonstrated typical findings of obstruction of the common bile duct, as well as cholelithiasis and thickening of the gallbladder wall. There was no demonstrable abnormality of the pancreas. At subsequent laparotomy, carcinoma of the gallbladder with widespread metastasis, including to the common bile duct, were discovered.

Case Report

A 70-year-old male was admitted to the hospital on Feb. 16, 1979, having become ill several weeks prior to admission with weight loss, anorexia, malaise, nausea, pruritis, diarrhea, light stools and progressively increasing painless jaundice.

His history included treatment for diabetes mellitus since 1972, mild hypertension and arteriosclerotic heart disease with mild left ventricular strain.

Laboratory examination indicated total bilirubin as high as 21 with some increase in alkaline phosphatase, SGOT and blood sugar. Ultrasound study demonstrated dilatation of the common bile and common hepatic ducts, as well as dilatation of the intrahepatic radicals, evidence of cholelithiasis and some thickening of the gallbladder wall (see Figures 1 and 2). A CT scan demonstrated multiple dilated intrahepatic radicals, some dilatation of the gallbladder, and thickening of the gallbladder wall.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Memorial Hospital,
Gulfport, MS.

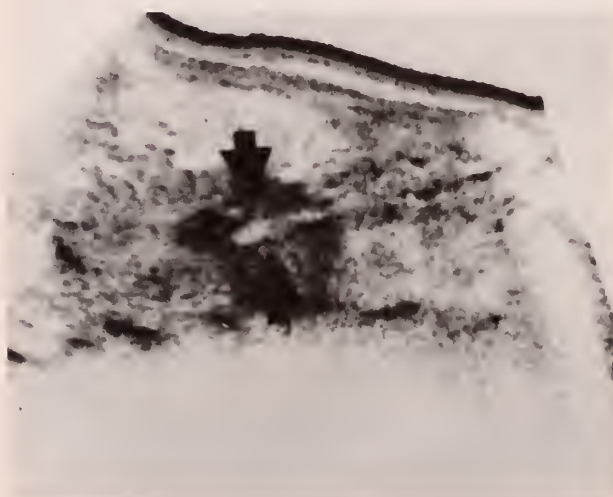


Figure 1. Shows a sagittal cut taken at the midline. A linear sonolucent structure beneath the liver is believed to represent a dilated common bile duct (arrows).

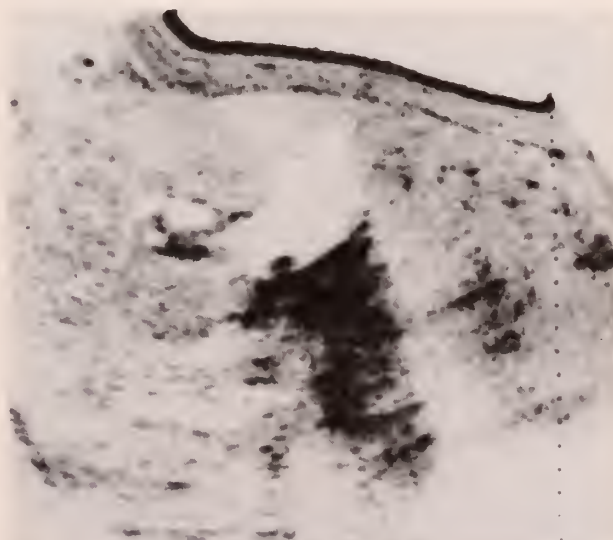


Figure 2. Evidence of a somewhat dilated gallbladder containing a stone.

OBSTRUCTIVE JAUNDICE / Barrett

There was also evidence of at least one calcified gallstone (see Figures 3, 4 and 5). No other abnormality was demonstrated on the CT scan, including no abnormality of the pancreas.

The patient subsequently went to surgery. At laparotomy, the gallbladder had the appearance of empyema with rupture, which had apparently happened just prior to surgery. The patient underwent a cholecystectomy and common bile duct exploration which revealed evidence of tumor involving the



Figure 3. Dilatation of multiple intrahepatic radicals.

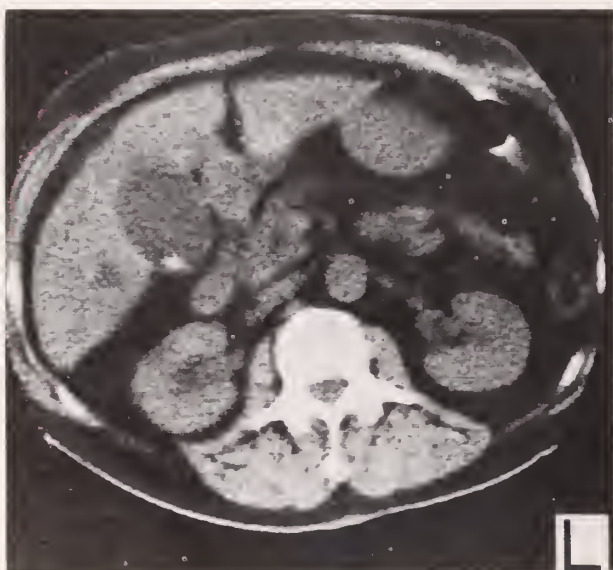


Figure 4. A calcified gallstone in a dilated gallbladder.

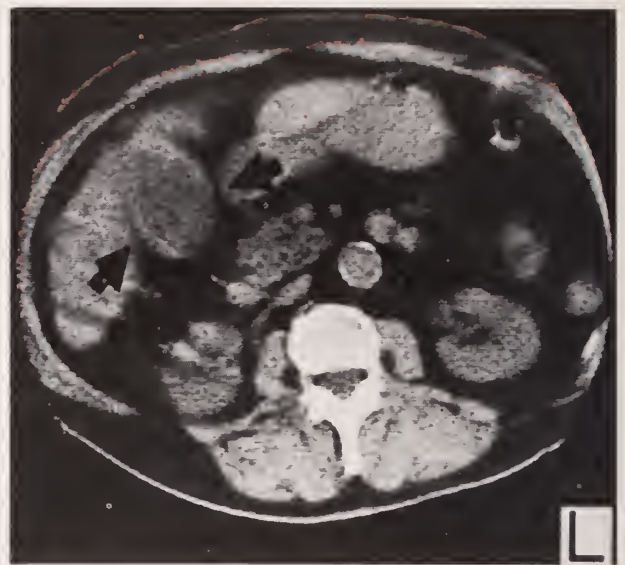


Figure 5. A dilated gallbladder with thickening of the gallbladder wall (arrows).

common bile duct. Partial excision of the tumor, choledochostomy and insertion of a T-Tube for drainage were then done.

Pathological diagnosis was poorly differentiated adenocarcinoma arising in the gallbladder epithelium and infiltrating the muscularis and adherent tissue, intramural necrosis with granulation tissue, and multifocal, hepatic cholestasis, with fibrosis and cholelithiasis. The carcinoma had metastasized widely with adenocarcinoma involving the common bile duct and porta hepatis.

Following surgery, the patient was seen by two oncologists for chemotherapy and radiotherapy. However, his condition rapidly deteriorated, and he expired on Mar. 30, 1979.

Discussion

The association of chronic inflammatory disease and cholelithiasis with gallbladder carcinoma is well documented. Increased thickness of the gallbladder wall is also known to be a sign of chronic cholecystitis.

In the above case obstruction of the common bile duct, cholelithiasis, and thickening of the gallbladder wall are well demonstrated by ultrasound and computerized tomography studies. Although not specific, the combination of these findings and a normal pancreas may suggest that the possibility of carcinoma of the gallbladder be included in the differential diagnosis of obstructive jaundice. ★★

P.O. Box 1810 (39501)

JOURNAL MSMA

Special Article

National Health Insurance — Can We Afford It?

Two articles which explore the question of National Health Insurance are reproduced from *Synergos*, the newsletter of the Mississippi Health Systems Agency. In an attempt to determine what NHI "will mean for us as health care consumers and providers," MHSA solicited responses from representatives of both groups.

The provider's viewpoint was written by MSMA Executive Secretary Charles L. Mathews. The consumer's viewpoint was written by Lon Larson, Ph.D., Adjunct Instructor at the University of Mississippi, Department of Health Care Administration.

A Provider's Viewpoint Charles L. Mathews

A national health insurance program for all Americans would mean less quality medical care for most Americans. Furthermore, such a program is unnecessary. It would increase medical care costs and it would not solve any of the major medical care problems facing the people of Mississippi.

The vast majority of Americans (over 180 million) now have their basic medical care needs met through insurance. Such insurance is generally financed through employer-employee contributions and provides a free choice of coverage limits and of physician, hospital and other health service.

National health insurance would be financed through a federally administered health care tax and would provide a set limit of benefits for all Americans regardless of need or personal preference. Furthermore, based on experiences of other countries we would have limited choices in selecting a physician, hospital or other health service under a national health insurance program. England is an example. There you are assigned to a physician, and "queuing" for health services is a common practice with certain types of surgery requiring months to obtain.

Proponents of a national health insurance program for our country claim that the program would reduce health care costs. This is ridiculous on its face, in light of the \$60 billion price tag placed on a national health insurance program and in light of our cost experience with other government programs. What national health insurance proponents should really say is that such a program would limit health care

services by placing them in a federal budget to compete with other national needs such as defense, public transportation and postal services.

No national health insurance program will solve Mississippi's shortage of physicians, nurses, and other health personnel. The four leading causes of death in our state — heart disease, cancer, stroke and accidents — will not be greatly reduced by a national health insurance program. All result primarily from lifestyle and heredity rather than from lack of medical care.

"It would increase medical care costs and it would not solve any of the major medical care problems facing the people of Mississippi."

There are things we can all do to assure that medical care in our country remains the best in the world. We should support charitable and governmental efforts to provide medical care for that small minority of Americans who through no fault of their own are unable to provide for their own medical care needs. We should discourage first-dollar-coverage of medical care costs, recognizing that such coverage encourages overutilization of health care services. We should encourage our federal government to utilize its taxing (exemption) powers to support employer-employee participation in catastrophic insurance coverage, recognizing that fear of cost of a catastrophic illness is one of the greatest concerns of all Americans.

Finally, we should encourage innovative medical care programs, recognizing that a pluralistic approach to providing medical care in a diverse country such as ours is much more favorable than a single national health insurance.

A Consumer's Viewpoint Lon Larson

Very few ideas are more appealing than that of being free of the potential economic burden posed by health care costs. After all, why should anyone have to worry about paying for medical care? In 1972, a more specific question was asked: why should anyone worry about the costs of life-saving renal dialysis? Congress decided such worry was uncalled for and extended Medicare benefits to anyone needing dialysis, regardless of age. Now, after dialysis clinics have sprung up like dandelions (to the demise of less costly home dialysis) and the costs of the

program have far exceeded expectations, the only ones worrying are congressmen — how do they pay for Medicaid and, as a corollary (not as a consequence), how do they keep the Social Security System solvent?

This brings us to a fundamental “law” of economics; namely, there is no such thing as a free lunch. Further, the analysis leads us to a thought-provoking aspect of medical care. That is, we are fast approaching the point where we are unable economically to afford to save every life that is technologically savable. (Remember the extraordinary efforts made to save Generalissimo Francisco Franco?) From these two observations, the basic premise of this paper emerges: unless caution and careful consideration are employed, national health insurance (NHI), in any form, will cost us a bundle — more than we can afford and more than the benefits derived from such a program. The possibility of costs exceeding benefits is based on the increasingly popular notion that factors other than medical care (e.g., life style, environment) play a large role in the attainment of healthiness.

“... a fundamental law of economics ... there is no such thing as a free lunch.”

Consequently, in analyzing NHI proposals, we must look at the manner in which the issue of cost containment is addressed. First, there is the “moral hazard” of health insurance. That is, insurance coverage increases the frequency of occurrence of the insured event; or in simpler terms, utilization increases with insurance. The moral hazard is usually regarded as applying to consumer behavior. However, about 80% of all health expenditures are the result of provider (most notably, physician) decisions, e.g., patients do not admit themselves to hospitals. A strong case can be made that the moral hazard of insurance also affects provider behavior. For instance, why not do another test or admit to the hospital, their insurance will cover it? This is not to blame either the consumer or the physician; the former wants to receive and the latter wants to provide care of the highest quality. Rather, the moral hazard is simply a rational response to insurance coverage. However, the time has come when economic considerations must be included in medical decisions. (Again, the case of Generalissimo Franco.) One mechanism to diminish the moral hazard is the employment of consumer cost-sharing. A strong case can be made for a large deductible (e.g., 10% of income, except for the poor) which

would, by law, not be insurable by any outside company. After all, if we are to assume more responsibility for our health by stopping smoking, starting jogging, and avoiding junk food, why can we also not assume some responsibility for the payment of our medical care?

“If the cost aspect of NHI is neglected ... we had better get ready to pay the bill.”

Another aspect of cost containment is the method used to determine provider reimbursement. The current “in thing” is to regulate hospital rates. While this technique may have merit, it is quite possible that the state of the art is not sufficiently advanced to yield that magic formula by which to derive fair and equitable rates. For instance, the success of New York’s rate regulation program in keeping hospital cost increases below the national average is often cited. Yet, the government recently had to bail one hospital out of bankruptcy. There is no question that bankrupting our hospitals would reduce health care costs, but is that an acceptable method? Let’s hope not. As an alternative to formulas, bargaining between groups of purchasers and groups of providers seems an attractive, albeit untried, option for establishing reimbursement rates. The point, put simply, is that methods of provider reimbursement, which are fair and also incite efficiency, are a prerequisite to a cost-effective NHI program.

Finally, NHI must provide opportunities for flexibility, innovation and experimentation. Again, the rudimentary state of the art prohibits us from deriving perfect solutions that can be set in concrete. Consequently, the role of the private sector with its ability to innovate in response to competitive forces must be assured in implementing NHI. Health maintenance organizations (HMO’s), which some feel are the salvation for health care delivery and should be mandated everywhere, originated in the private sector long before federal grants were available for such projects. Insurers and delivery organizations should be given the freedom to choose among prepayment plans. As evidence that the author is not alone in advocating a significant role for the private sector, Senator Kennedy’s most recent NHI proposal, in stark contrast to some of his earlier ones, includes such a strategy.

To conclude, national health insurance can be a desirable element in the nation’s health policy agenda, if the proper concern is given to its economic consequences. If the cost aspect of NHI is neglected, however, we had better get ready to pay the bill.

Counsel to Authors

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Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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The President Speaking

Banquet Night at Annual Session

GERALD P. GABLE, M.D.

Hattiesburg, Mississippi

The highlight of the Annual Session banquet planned by the Council on Scientific Assembly is an appearance by ABC news commentator Howard K. Smith. I am sure that all of the membership will look forward to the opportunity to hear such an outstanding guest speaker, and I am sure that when you are approached by your wife or other auxiliary member to purchase tickets to this occasion, you will ask yourself how the association can sponsor such an event at such a bargain price. This question should be answered by my letter to Mr. Paul W. McMullan, Chairman of the Board of the First Mississippi National Bank, which appears below. I hope that each of you will express to Mr. McMullan our sincere appreciation for his generosity and will remember the bank's motto of "Complete banking services from the Coast to the Capital."

Mr. Paul W. McMullan
Chairman of the Board
First Mississippi National Bank
P.O. Drawer 1231
Hattiesburg, Mississippi 39401

Dear Paul:

On behalf of the officers and members of the Mississippi State Medical Association, I would like to express to you our deep appreciation for your offer of the First Mississippi National Bank to sponsor Mr. Howard K. Smith as guest speaker at the Annual Convention Banquet in Biloxi on Wednesday, April 30, 1980.

I feel deeply moved that you have chosen to honor the President of the Medical Association "as a hometown boy" in this manner, and I am sure that it will serve as an excellent public relations effort with the physicians of the entire state. I shall see to it that your generosity is acknowledged statewide in the Association publications.

I look forward to having you and Georgie as our guests for the occasion.

Most sincerely,

A handwritten signature in dark ink, appearing to read "G. Gable". The signature is stylized with a large initial "G" and a cursive "Gable".

Gerald P. Gable, M.D.
President

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 3

MARCH 1980

Political Problem-solving — Expect More of the Same

As we enter the 1980s and pause to consider the status of medicine, we can be reassured that we are still the most respected of professions, even if we have perhaps lost a little of our public image.

Medical costs continue to escalate, perhaps somewhat out of proportion to the general inflationary trend, but many factors are responsible for this. For those who are ill or injured, their chances for recovery are far better than ever before in history. Coronary bypass surgery, while still controversial in some areas, certainly offers almost total palliation, and in many cases seems almost curative. While the world appears to be in turmoil, and man's inhumanity to man never seems to improve, it is reassuring to know that the medical profession throughout the world seems reasonably harmonious and cooperative.

We face grave national problems that will likely become more acute during the next decade: energy, defense, and rapid inflation. A fourth problem, of even greater import but perhaps not as acute, is that of overpopulation.

Ecologists throughout the world cry loudly for the preservation of habitat for our wildlife, but little is said about the preservation of habitat for human life. The world is not infinite, and our resources are not infinite. Environmentalists cry loudly about the dangers of nuclear energy, and I believe that everyone recognizes the possible hazards involved. In the final analysis, it is the demands of an ever-expanding population for rapidly shrinking resources that results in the necessity for these alternate sources of energy. We have the know-how to confront our population problem without forcing the will of some over the objections of others.

China, recognizing its population problem, is beginning to tax those who have children, the tax increasing with the size of the family. We, on the other hand, are still subsidizing childbearing by

giving a tax break to those who have children and increasing welfare payments to recipients who continue to bear more children. This latter segment of our society is probably less aware of the danger of overpopulation than any other. Admittedly, the more affluent cause more pollution and use more energy, but it is this very element who are aware of the dangers of overpopulation and who are limiting the size of their families. There may be a few who would rather see people starve than to embrace the alternative, but I would like to think that they are very much in the minority.

After listening to the Republican Presidential candidates debate a few days ago, it is my impression that we can only expect more of the same. The American people are not going to ration themselves, and our politicians are not going to discuss controversial social issues. Until we limit our elected representatives on a national level to two terms, I do not believe we can ever expect any appreciable change in the direction of government. Social issues will not be addressed constructively as long as a politician's first consideration is re-election!

W. MONCURE DABNEY, M.D.
Editor
Crystal Springs, MS

LETTERS

SIRS: I have read with interest information in your January issue concerning the Medicaid financial problems and after having seen similar concerns expressed in the local newspaper, I would like to make a few comments.

There is little doubt that the financing of health care by government at any level can be a bottomless pit unless constraints and guidelines of a realistic nature are adhered to. I do feel, however, that the present approach by the Medicaid Commission is

LETTERS / Continued

piecemeal and does not give one the impression that they have long-term goals and objectives that are in the best interest of the poor and disadvantaged people of this state who require and need access to appropriate health care.

I do support them in their endeavors to have all patients participate to some degree in a co-payment system. Having observed the development of a national health care system elsewhere, I believe that patients paying for some portion of services will lead to less abuse of the system, with minimal disadvantages in the quality of health care given. I am sure that there will be some patients who will not receive appropriate care because of this, but in general, overall health care will suffer minimally.

The curtailment of support for outpatient activities is unwise, since if we are to have any impact whatsoever on the utilization of hospital facilities, we have to increase our outpatient participation and assessment of patients prior to hospitalization, and more money should be directed to this area, rather than less. On the other hand, I believe that a decrease in payment for prescription drugs is worth the effort and I would even think that in most cases, fewer visits to doctors would have little impact on overall health care.

The curtailment of allowable inpatient hospital

days is unwise. This will place a tremendous burden on the patient and, indeed, the hospitals who require funds to maintain their support services to give adequate care. Certainly paying the hospitals at 60th percentile as suggested would also throw an extra financial burden on hospitals, especially those who have a significant proportion of Medicaid patients. The natural sequence of this would be that overall care to all patients would therefore diminish.

The Medicaid Commission should be realistic in assessing health care needs for the state of Mississippi. In the same issue of your journal, it was pointed out that tuberculosis, syphilis, and gonorrhea have been increasing in Mississippi and that tuberculosis had the highest rate of any state within the union.

It is apparent that an infusion of funds is needed into the system, not less. This should, however, be associated with increasing patient responsibility and an increased emphasis on outpatient or ambulatory programs. After all, the legislators had ample funds to infuse several million dollars into the local football stadium, not all of which will come from the sale of tickets.

WILLIAM C. NICHOLAS, M.D.
Director of Outpatient Clinics &
Associate Professor of Medicine
University Medical Center
Jackson, MS

PRACTICE MANAGEMENT MAILBOX

Terminating the Physician — Patient Relationship

In almost every practice setting there comes a time when a doctor is faced with terminating his relationship with a patient. Quite naturally, this situation occurs for a variety of reasons and is not a pleasant task. Often, the patient's feelings are hurt, and sometimes the patient wants to retaliate.

Proper actions by the physician can ease the tension created by the termination and avoid any negative reaction by the patient. The following suggestions are made in conformance with the *Principles of Medical Ethics* and represent the "proper" way to terminate a patient.

The treating physician should give the patient written notice that the relationship is to be terminated. The notice should state the date of termination which should be at least thirty (30) days from the date

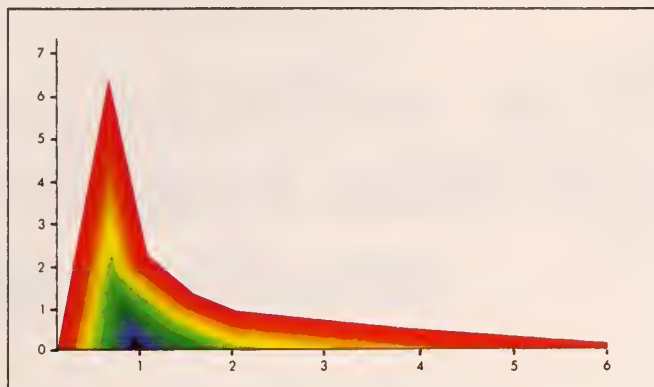
of the letter. (There is no need to state the particular reasons for termination.)

Additionally, the letter should advise the patient that he should seek the services of another physician and that upon proper authorization, the patient's medical record (or a proper summary) will be made available to the new physician.

Above all, the termination letter should be nice and should offer any assistance to the patient that might be appropriate. Keep in mind that the relationship does not cease until the termination date specified in the letter and that the physician must continue to treat the patient until that time if the patient so desires. — B.C.M.

(Editor's Note: Your questions about practice management will be answered in this column. Please direct your questions to "Practice Management Mailbox," P.O. Box 5229, Jackson, MS 39216.)

more
than just spectrum



New **CYCLAPEN**[®]
(cyclacillin) Tablets/
Suspension

**Efficacy
proven in the
treatment of
bronchitis,
pneumonia,
upper respiratory
tract infections
and otitis media*
with fewer
side effects.**



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN[®]

(cyclacillin) Tablets/
Suspension

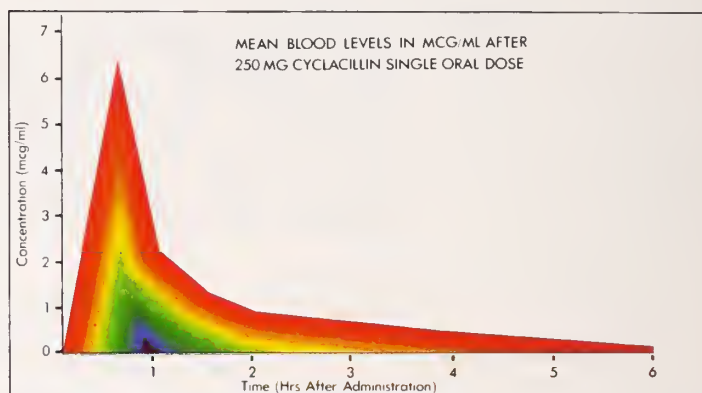
efficacy with fewer side ampicillin confirmed in studies of 2,581

Rapid, virtually complete
absorption from GI tract

Rapid onset of action—
mean peak serum levels
within 30 minutes

Exceptionally high peak
blood levels—3 times
greater than ampicillin
(clinical efficacy may not
always correlate with
blood levels)

Rapidly excreted
unchanged in the urine—
1½ times faster than
ampicillin



High cure rate with CYCLAPEN [®]		
Causative Organism	Bronchitis/Pneumonia [†]	No. of Patients
<i>S. pneumoniae</i>	100	73
	95	
Chronic Bronchitis [†] (acute exacerbation)		
<i>H. influenzae</i>	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to <i>H. influenzae</i>	
Streptococcal Sore Throat [†]		
Group A beta-hemolytic Streptococcus	100	44
	86	
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>		

more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections[†]

*Includes all patients treated. 2,415 evaluated for safety;
1,819 evaluated for efficacy.

[†]Due to susceptible organisms.

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effects than double-blind patients*

Fewer side effects with CYCLAPEN® in
double-blind studies to date^{1,2}

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant ($P < 0.001$)	

CYCLAPEN® (cyclacillin)

Effective for bronchitis, pneumonia,
and upper respiratory tract infections†

- Excellent clinical results in bronchitis,
pneumonia and upper respiratory tract
infections
- Significantly lower incidence of diarrhea
and skin rash

1. Gald JA, Hegarty CP, Deitch MW, Walker BR:
Double-blind clinical trials of oral cyclacillin
and ampicillin, *Antimicrob Ag Chemother*
15:55-58, (Jan.) 1979.

2. Data on file, Wyeth Laboratories.



more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
<i>S. pneumoniae</i>	% Clinical Response	82
	% Bacterial Eradication	
<i>H. influenzae</i>	% Clinical Response	96
	% Bacterial Eradication	

more than
just spectrum
CYCLAPEN®
(cyclacillin) Tablets/
Suspension

New from Wyeth Laboratories

CYCLAPEN[®]
(cyclacillin) Tablets/
Suspension

**more than just spectrum in bronchitis,
pneumonia, upper respiratory tract
infections and otitis media***

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN[®] Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied
CYCLAPEN[®] (cyclacillin)
tablets:
250 mg scored tablets
500 mg scored tablets

Indications

Cyclapen[®] (cyclacillin) has less *in vitro* activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen[®] is indicated for the treatment of the following infections.

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci, bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*).

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*.

Acute exacerbation of chronic bronchitis caused by *H. influenzae*.*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (Integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLAPEN[®] SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLAPEN[®] HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS. SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN. ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated

CYCLAPEN[®] (cyclacillin) for
oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS.)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

	ADULTS	CHILDREN
Respiratory Tract Infections & Pharyngitis**	250 mg q.i.d. in equally spaced doses	Dosage should not result in a dose higher than that for adults. body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

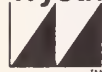
Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥10 mg %, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa 19101



Council Finalizes Plans for MSMA's 112th Annual Session

The Council on Scientific Assembly has initiated several changes in the format for the association's 112th Annual Session, set for April 27-May 1 at the Biloxi Hilton. The changes are expected to facilitate scheduling of scientific sessions, business meetings and fellowship activities, and produce a more general scientific program, according to Dr. J. Elmer Nix, Council chairman.

Several scientific sections are collaborating on plans for continuing medical education sessions. The first day's scientific program will combine the Sections on Anesthesiology, EENT, Radiology, Orthopedic Surgery and Surgery. The three-hour scientific program slated for Tuesday, April 29, has been planned by representatives of the Sections on Family Practice, Urology, Ob-Gyn, Pediatrics and Psychiatry. Wednesday's scientific program will feature courses scheduled by Sections on Pathology, Medicine, Dermatology and Preventive Medicine.

In addition to scientific sessions, some 20 medical specialty and alumni groups are also planning meetings. Annual membership meetings of the Mississippi Foundation for Medical Care and the Mississippi Medical Fraternal and Educational Society have been scheduled.

The House of Delegates will meet on Monday and

Thursday, with Reference Committee meetings scheduled for Monday afternoon.

Highlighting the program of special events will be a membership banquet on Wednesday evening, featuring an address by ABC news commentator Howard K. Smith.

A golf tournament has been added to the schedule of special events planned by the Council. Both the annual tennis tournament and the golf tournament will be conducted Tuesday afternoon. A practice management breakfast-seminar is slated for Wednesday morning.

The 57th annual session of the Mississippi State Medical Association Auxiliary will be held in conjunction with the MSMA meet. Mrs. Jim C. Barnett of Brookhaven is president of the auxiliary and Mrs. Curtis D. Roberts of Brandon is president-elect.

More information will be provided in upcoming issues of the "Blue Sheet," and the complete Annual Session program will be published in the April issue of JOURNAL MSMA.

MSMA Sponsors Jail Health Seminar

More than 30 sheriffs and jailers from around the state attended the Receiving Screening Training Session sponsored by MSMA last month at the Jackson Hilton.

Virginia S. Tolbert, M.D., chairman of the Jail Project Advisory Committee, welcomed the representatives and stressed the importance of adequate medical care for inmates.

Instructor for the workshop was Sara Klein, R.N., coordinator for the Indiana State Medical Association's jail health project. She discussed receiving screening measures, the recognition of signs and symptoms of diseases common to inmates, following medical orders and the administration of medications. Training in these areas qualify jail staff members to meet several of the American Medical Association's Standards for Health Services in jails.

The MSMA Jail Project Advisory Committee met in conjunction with the workshop. Ella Tardy, project coordinator, reported that all 12 of the participating jails



ABC news commentator Howard K. Smith will be the featured speaker at the MSMA membership banquet planned for the 112th Annual Session in Biloxi.

in Mississippi have made improvements in their health systems, including the initiation of receiving screening, preparation of routine health appraisals of long-term inmates, and development of health records systems. Some jails have developed manuals for jailers regarding policies and procedures and manuals for prisoners regarding access to health care.

Several of the state jails in the project will be ready for upcoming accreditation reviews.

There is still a need to recruit physicians to work with jails in three geographic areas. MSMA members soon will receive a letter about the project and will have the opportunity to view a display during annual session.



Sheriffs and jailers from all areas of the state attended the Receiving Screening Training Session conducted last month as part of MSMA's Jail Health Project. Pictured are, from left, Coahoma County Sheriff Jesse Bonner of Clarksdale; Dr. Virginia Tolbert of Parchman Hospital, chairman of MSMA's Jail Project Advisory Committee; Richard Belding, jail administrator of Copiah County; and Sara Klein, R.N., of Indiana, instructor for the session.

Biloxi Will Host Tri-State Scientific Sessions

The 1980 Tri-State Scientific Sessions for Physicians will be held Apr. 17-18 at the Biloxi Hilton. The theme is "Cardiology 1980 — Advances in Diagnosis and Treatment."

Dr. Quinton Dickerson of Jackson is chairman of the seminar. Further information and registration forms are available from the American Heart Association — Mississippi Affiliate, 4830 East McWillie Circle, P.O. Box 16063, Jackson, MS 39206, telephone (601) 981-4721.

Death Claims Former President

Dr. Lamar Arrington of Meridian, a past president of MSMA and a longtime member of the association's board of trustees, died Jan. 20.

A native of Monticello, Dr. Arrington had been a practicing physician in Meridian from 1928 until his retirement in 1972. He received his bachelor of science degree from the University of Mississippi and his medical degree from Tulane University Medical School. He interned at Touro Infirmary in New Orleans, the Vicksburg Charity Hospital, Laurel Charity Hospital, Matty Hersee Hospital in Meridian and Barnes Hospital Group in St. Louis, MO.



Dr. Arrington was a past president of the Lauderdale County Medical Society and the East Mississippi Medical Society. He held membership in Southern Medical Association, in which he served as counselor for five years, and the American Medical Association. He was a founder and a director of Blue Cross-Blue Shield of Mississippi, Inc. for 22 years. He served as a member of the Mississippi State Board of Health from 1958 until his death. He was a fellow of the American Academy of Pediatrics and of the American College of Physicians.

In 1976 MSMA joined the East Mississippi Medical Society in honoring Dr. Arrington on his 50 years of membership and service to the association.

Hospital Group Purchasing Cuts Costs

Some 55 hospitals in Mississippi are participating in a Group Purchase Program conducted by the Mississippi Hospital Association. The program was implemented in order to help restrain the rate of increase in hospital costs and to further the Voluntary Cost Containment Program initiated by the American Medical Association, American Hospital Association and Federation of American Hospitals.

The purpose of the program is to effect a savings to individual hospitals in the purchase of medical and surgical supplies on a volume basis. Two key elements in the success or failure of such a program are

the standardization of products and supplies and the cooperation of the medical staff in the individual hospitals.

An example of the savings is shown in three contracts recently awarded by the program. Contracts for surgeons' gloves, shoe covers and povidone-iodine products provided a savings of \$115,000 to the participating hospitals.

Abbott Laboratories Honors Dr. Brumby



Dr. Paul Brumby, right, receives a Jefferson Gold Hour Clock from Dave Smith, area professional medical representative of Abbott Laboratories of North Chicago, IL. The award was made in honor of Dr. Brumby's many years of medical service. The Lexington family physician has practiced in the Holmes County area for more than 50 years. Dr. Brumby is a former president of MSMA.

112th Annual Session of MSMA

April 27-May 1, 1980
Biloxi Hilton

Mark Your Calendars Now!

Auxiliary Hosts Legislators At Luncheon



More than 125 legislators were guests at a luncheon sponsored by MSMA's Auxiliary last month. Pictured with Rep. Rick Lambert of Forrest County are, from left, Mrs. William R. Raulston, Mrs. Emmett Herring, Jr., and Mrs. Milam Cotten, all of Hattiesburg. Special guest speaker was Mrs. Brad Dye.

PERSONALS

GEORGE E. ABRAHAM, II, of Vicksburg announces the association of JOHN ROBERT FORD in practice at the Family Medicine Clinic, 1011 Mission 66.

JAMES ACHORD of UMC attended a recent executive committee meeting of the American College of Gastroenterology in New York.

G. WILLIAM BATES of UMC was guest speaker at Bowman Gray Medical School in Greensboro, NC.

W. MEL FLOWERS of UMC attended a board of trustees meeting of the Society of Nuclear Medicine in Miami Beach.

MARTIN B. HARTHCOCK of Jackson announces the relocation of his office for the practice of plastic and reconstructive surgery to 210 Hinds Professional Building, 1815 Hospital Drive.

CARL EVERS of UMC attended an Atlanta planning meeting of the Southern Group on Student Affairs, Association of American Medical Colleges, as a member of that organization's executive committee.

JOHN JACKSON of UMC presented a paper at the Southern Society for Clinical Investigation meetings in New Orleans and lectured at a seminar in Jackson sponsored by the Southern Farm Bureau Life Insurance Company.

JOHN KILEY of UMC was honored during the formal dedication of the new hemodialysis center at the Albany (New York) Medical Center Hospital. Dr. Kiley was chief of the division of kidney diseases at Albany from 1960-77 and began the dialysis program there.

PERSONALS / Continued

HERBERT LANGFORD of UMC was in New York recently to write the manual of operations for the Dietary Modification of Blood Pressure study.

MYRON LOCKEY of UMC spoke at a recent meeting of the Memphis Otolaryngic Society and was visiting professor at the University of Tennessee.

NORMAN C. NELSON of UMC spoke at a recent continuing education meeting in Lafayette, LA.

JACK RAWSON of Jackson received an award during the March of Dimes Foundation's annual meeting in January, in recognition of his work as state chairman.

FRED M. SANDIFER, III, of Greenwood was inducted as a fellow of the American Academy of Orthopaedic Surgeons at the association's annual meeting in Atlanta.

CLIFFORD ALLEN SEYLER of Pascagoula was recently nominated for the Pascagoula Jaycees "Outstanding Young Man of 1979" award.

WALTER R. SHELTON of Jackson has associated with Central Orthopedic Clinic (GEORGE D. PURVIS, THOMAS C. TURNER, WILLIAM B. THOMPSON, JAMES O. MANNING and GEORGE W. TRUETT) at 421 South Stadium Circle.

BILL THORNTON is serving as president of the 1980 Greater Meridian Chamber of Commerce.

DAVID WATSON of UMC spoke at a recent meeting of the Columbia Lions Club in Columbia.

RAY WESSON of Biloxi was recently elected chief of staff of Howard Memorial Hospital.

RONALD B. WILLIAMS of Jackson announces the relocation of his office for the practice of anesthesiology to Highland Village, 4500 I-55 North, Suite 249.

DEATHS

HUME, CHARLES R., Vicksburg. Born Milroy, IN, Oct. 22, 1911; M.D., Tulane University School of Medicine, New Orleans, LA, 1936; interned Touro Infirmary, New Orleans, one year; EENT residency, EENT Hospital, New Orleans, 1937-39; died Jan. 6, 1980, age 68.

Tenuate®

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in the evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in the morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES

Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M. T., O'Dillon, D. H., and Leyland, H. M. A comprehensive review of diethylpropion hydrochloride. In: *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

**Overweight may not always be simple...
complications can develop*.
Complicated or not...**

Tenuate[®] Dospan[®] ^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**



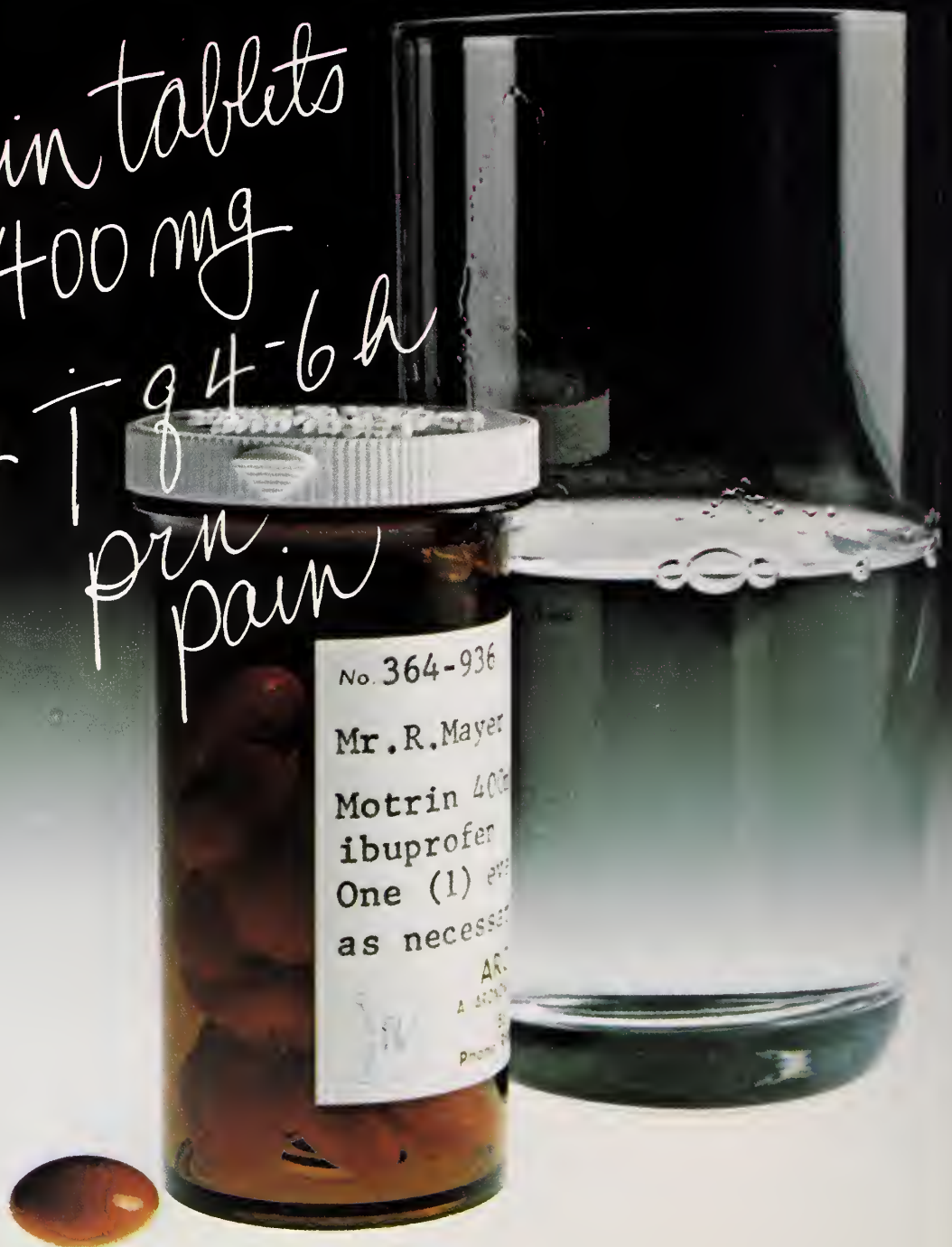
*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

A well-tolerated, nonnarcotic prescription for pain

Motrin tablets
400 mg
Sig T q 4-6 h
prn
pain



Motrin[®] now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400^{TABLETS}mg
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

MEETINGS

National and Regional

American Medical Association Winter Scientific Meeting, January 12-15, 1980, San Antonio, TX; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 1980, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 112th Annual Session, April 27, 1980, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1611, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter Dawkins, Secy., 131 Jeff Davis Blvd., Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Thomas Waller, Secy., P.O. Box 1487, Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Bruner B. Bosio, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Doug Thomas, Secy., 415 S. 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly Mississippi State Medical Association 735 Riverside Drive Jackson, MS 39216	Northwest Mississippi Regional Medical Center Box 1218 Clarksdale, MS 38614
North Mississippi Medical Center 830 Gloster Avenue Tupelo, MS 38801	Mississippi Chapter American College of Surgeons Box 5229 Jackson, MS 39216
Forrest General Hospital Box 1897 Hattiesburg, MS 39401	Mercy Regional Medical Center 100 McAuley Drive Vicksburg, MS 39180
Mississippi Baptist Hospital 1225 N. State Street Jackson, MS 39201	St. Dominic-Jackson Memorial Hospital Lakeland Drive Jackson, MS 39216
Gulf Coast Community Hospital 4642 W. Beach Boulevard Biloxi, MS 39531	North Panola County Hospital Drawer 160 Sardis, MS 38666
Jefferson Davis Memorial Hospital Box 1488 Natchez, MS 39120	Singing River Hospital 2809 Denny Avenue Pascagoula, MS 39567
King's Daughter Hospital Box 948 Brookhaven, MS 39601	Magnolia Hospital Alcorn Drive Corinth, MS 38834
Delta Medical Center Greenville, MS 38701	Greenwood Leflore Hospital 1508 Leflore Avenue Greenwood, MS 38930
Riverside Hospital Lakeland Drive Jackson, MS 39208	



Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68%*	93%**
Mintezol ¹	35%†	45%††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.[®]

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

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JPI-023



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermax[®]
(mebendazole)
TABLETS

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

NEW MEMBERS

BAINE, RODNEY W., Clarksdale. Born Rockford, IL, Sept. 22, 1945; M.D., University of Tennessee College of Medicine, Memphis, 1970; interned Baptist Hospital, Memphis, one year; general surgery residency, same, 1971-75; elected by Clarksdale and Six Counties Medical Society.

BREWER, DAVID W., Meridian. Born Syracuse, NY, Mar. 4, 1943; M.D., State University of New York College of Medicine, Syracuse, 1971; interned New York Upstate Medical Center, Syracuse, one year; ob-gyn residency, same, 1972-75; elected by East Mississippi Medical Society.

BUSH, GEORGE R., Laurel. Born Laurel, MS, Dec. 3, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; family medicine residency, same, 1977-79; elected by South Mississippi Medical Society.

CHRISTIAN, THOMAS W., Jackson. Born Algiers, LA, Sept. 27, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned University Medical Center Jackson, one year; pediatric residency, same, 1974-77; allergy-clinical immunology residency, National Asthma Center, Denver, CO 1977-79; elected by Central Medical Society.

CONERLY, DONALD V., Petal. Born McComb, MS, Aug. 16, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University Medical Center, Jackson, one year; family practice residency, same, 1976-78; elected by South Mississippi Medical Society.

GARTH, WILLIAM P., Jackson. Born Jackson, MS, June 13, 1947; M.D., Tulane University School of Medicine, New Orleans, LA, 1973; interned Duke University Hospital, Durham, NC, 1973-75; orthopedic surgery residency, Campbell Clinic, Memphis, TN, 1976-79; elected by Central Medical Society.

GEMELLARO, VINCENT, Jackson. Born Lawrence, MA, Mar. 2, 1943; M.D., University of Miami School of Medicine, Miami, FL, 1971; interned New York University Medical Center, New York City, one year; pathology residency, University of Miami, 1972-74; pathology residency, New York University Medical Center, 1974-76; elected by Central Medical Society.

NEW MEMBERS / Continued

GORDON, GARY G., Meridian. Born Houston, MS, Oct. 3, 1938; D.O., Kansas City College of Osteopathic Medicine, 1974; interned Madigan Army Medical Center, Tacoma, WA, one year; elected by East Mississippi Medical Society.

HERRINGTON, ROBERT R., III, Columbia. Born Hattiesburg, MS, Sept. 25, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; family practice residency, same, 1977-79; elected by South Mississippi Medical Society.

JOHNSON, JOHN WILCOX, Jackson. Born Cookeville, TN, June 25, 1945; M.D., University of Tennessee College of Medicine, Memphis, 1971; interned Dallas Methodist Hospital, Dallas, TX, one year; anesthesiology residency, Parkland Memorial Hospital, Dallas, 1972-74; anesthesiology fellowship, Parkland Hospital and Southwestern Medical School, Dallas, 1974-75; elected by Central Medical Society.

MATTIEU, DONALD E., JR., Hattiesburg. Born Birmingham, AL, Oct. 12, 1946; M.D., Bowman Gray School of Medicine, Winston-Salem, NC, 1972; interned North Carolina Baptist Hospital, Winston-Salem, one year; pathology residency, same, 1973-76; elected by South Mississippi Medical Society.

McFARLAND, THOMAS R., Lumberton. Born Wetumpka, AL, Mar. 17, 1946; M.D., Loma Linda University School of Medicine, Loma Linda-Los Angeles, CA 1977; interned Florida Hospital, Orlando, 1977-78; elected by South Mississippi Medical Society.

McRANEY, T. O., Picayune. Born De Ridder, LA, Feb. 27, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, 1976-77; elected by Pearl River County Medical Society.

MEADORS, MARVIN P., JR., Jackson. Born Memphis, TN, Aug. 18, 1933; M.D., Tulane University School of Medicine, New Orleans, LA, 1959; interned Touro Infirmary, New Orleans, one year; ENT residency, Tulane and Charity Hospital, New Orleans, 1960-61; general practice residency, Touro Infirmary, New Orleans, 1963-64; pathology residency, Baptist Memorial Hospital, Memphis, TN, 1966-70; elected by Central Medical Society.

PARKMAN, CHARLES J., Hattiesburg. Born Columbia, LA, June 15, 1945; M.D., University of Mississippi School of Medicine, 1970; interned same, one year; internal medicine residency, same, July-Sept. 1971 and 1973-75; pulmonary residency, same, 1975-77; elected by South Mississippi Medical Society.

PAYNE, JOEL G., JR., Jackson. Born Jackson, MS, Aug. 2, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Brooke Army Medical Center, San Antonio, TX, one year; ob-gyn residency, University Medical Center, Jackson, 1976-79; elected by Central Medical Society.

SANDERS, JANE A., Jackson. Born Kosciusko, MS, Oct. 16, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Touro Infirmary, New Orleans, LA, 1969-70; radiology residency, Charity Hospital, New Orleans, 1970-72; radiology residency, City of Memphis Hospital, Memphis, TN, 1972-73; elected by Central Medical Society.

SMITH, W. H., JR., Jackson. Born Atlanta, GA, Sept. 28, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned, University Medical Center, Jackson, one year; pediatric residency, same, 1977-79; elected by Central Medical Society.

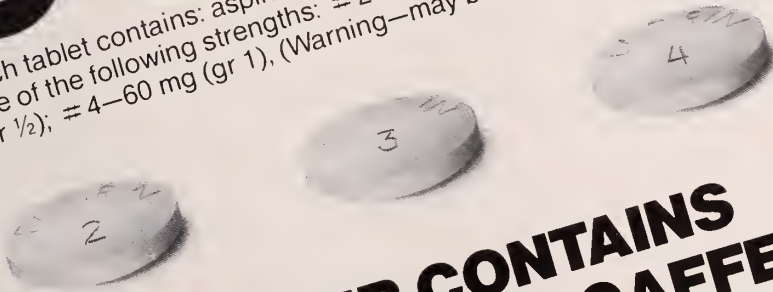
VENTERS, DAVID B., Grenada. Born Winnipeg, Canada, May 27, 1929; M.D., University of Alberta Faculty of Medicine, Edmonton, Alberta, Canada, 1954; interned St. Paul's Hospital, Saskatoon, Canada, one year; radiology residency, University of Florida Medical Center, Gainesville, 1969-72; elected by North Central Medical Society.

WALLACE, WILLIAM H., Jackson. Born Jackson, MS, Feb. 3, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned University of Virginia Hospital, Charlottesville, one year; general surgery residency, University Medical Center, Jackson, 1973-77; plastic surgery residency, same, 1977-79; elected by Central Medical Society.

WILLIAMS, J. E., III, Hattiesburg. Born Baton Rouge, LA, May 6, 1947; M.D., Louisiana State University School of Medicine, New Orleans, 1973; interned Wilford Hall USAF Medical Center, Lackland, AFB, TX, one year; pathology residency, same, 1974-77; elected by South Mississippi Medical Society.

~~EMPIRIN[®]~~ ~~COMPOUND~~ ~~CODINE~~ IS NOW ~~EMPIRIN[®]~~ ~~CODINE~~

Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: \pm 2–15 mg (gr $\frac{1}{4}$); \pm 3–30 mg (gr $\frac{1}{2}$); \pm 4–60 mg (gr 1), (Warning—may be habit-forming)



**NO LONGER CONTAINS
PHENACETIN OR CAFFEINE.**



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

A woman with dark hair tied back, wearing a white chef's uniform, is focused on her work in a kitchen. She is leaning over a large, dark, rectangular tray or pan that is filled with rows of golden-brown, elongated food items, possibly fried fish or vegetables. The background is dark and out of focus, showing some kitchen equipment. The text "getting back to business" is overlaid in a bold, white, sans-serif font on the right side of the image.

**getting back
to business**

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

**for moderate anxiety
with depression**

dual-action
Triavil[®]
containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
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SHARP
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*Please see the following page
for a brief summary
of prescribing information.*

by providing symptomatic relief
of moderate anxiety with depression

Dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:

TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone. **Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonian agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema, reversed epinephrine effect, hyperglycemia, endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle), altered cerebrospinal fluid proteins; paradoxical excitement, hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation, delusions; hallucinations; excitement, anxiety; restlessness; insomnia, nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia, eosinophilia, purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness, fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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POSTGRADUATE CALENDAR

March 13-15, 1980

SURGICAL FORUM VII

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the Medical Center Division of Continuing Health Professional Education.

Coordinator: James D. Hardy, M.D., professor of surgery and chairman of the department, University of Mississippi School of Medicine.

This seventh annual forum is for the general surgeon. Internationally recognized guest lecturers will join UMC faculty in presenting sessions during the three-day program. Fee: \$175. Credit: 17 contact hours (1.7 CEU) Category I of the Physician's Recognition Award, AMA.

March 21-22, 1980

ONCOLOGY II

Holiday Inn North, Jackson

Sponsored by the University of Mississippi School of Medicine and the Medical Center Division of Continuing Health Professional Education in cooperation with the Mississippi Oncological Society.

Coordinator: J. Tate Thigpen, M.D., associate professor of medicine and oncology division director, University of Mississippi School of Medicine.

This is the second in a series of symposia planned for the general practitioner, internist, surgeon and radiation therapist. The program will present current information in rapidly changing and important areas of clinical oncology. Fee: \$40 (includes banquet on Friday evening). Credit: 8 contact hours (.8 CEU), Category I of the Physician's Recognition Award, AMA; AAFP.

March 27-28, 1980

CLINICAL NEUROLOGY REVIEW

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Shri K. Mishra, M.D., assistant professor of neurology, University of Mississippi

School of Medicine, and neurology service chief, Veterans Administration Medical Center.

This two-day program is designed for the family and general medicine practitioner, neurologist, neurosurgeon, internist, psychiatrist and pediatrician. Sessions will focus on recent advances in diagnosis and treatment of common neurological disorders of higher cortical functions disorders. Fee: \$130. Credit: 13 contact hours (1.3 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

April 3-4, 1980

INFECTION IN THE NEWBORN

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the Division of Newborn Medicine, and Gwen Bussa, R.N., M.N., C.N.M., assistant professor, School of Nursing, and instructor in obstetrics and gynecology (nurse-midwifery), School of Medicine.

Sessions will include normal immunological responses of the fetus and newborn. Pathophysiological response of the infected newborn will be emphasized. Current methods of medical intervention will be discussed. The course is limited to 10 participants. Fee: \$50. Credit: 12 contact hours (1.2 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

FUTURE CALENDAR

May 3-4, 1980

CARDIOVASCULAR NUCLEAR MEDICINE

University Medical Center, Jackson

May 6-10, 1980

HAND SURGERY

Ocean Springs, Mississippi

July 16-17, 1980

NEWBORN METABOLISM

University Medical Center, Jackson

April 10-12, 1980

LIVER DISEASE UPDATE

Holiday Inn Downtown, Jackson

RECOLLECTIONS

The March 1961 issue of JOURNAL MSMA reported that the Board of Trustees of the AMA had registered a protest against a CBS television show, "The Business of Health: Medicine, Money and Politics." MSMA endorsed the action, calling the program "little more than a series of patent distortions and out-of-context references to the circumstances under which medical care is provided by American physicians."

Original papers included "Cancer Therapy Combinations: A Case Report," by Dr. Lawrence W. Long of Jackson and "The Present Status of Smoking and Cancer of the Lungs," by Dr. Guy T. Vise of Meridian.

An editorial by Dr. Thomas J. Marland, editor, explored the growth of statistics and called for a re-examination of their application to medicine. He declared, "If facts replace our power of reasoning, then we deteriorate into something less than intelligent, communicative and sensitive individuals," and he concluded that "in spite of the scientific aspects of medicine, it is still very much an art, especially in the doctor's office and at the bedside."

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for the better*

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PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

FAMILY PRACTITIONER or general practitioner with surgery interest. Free office space. Moving expenses paid. Modern 36-bed hospital with 60-bed extended care facility. Contact: Nick Wilson, Administrator, Quitman County Hospital, Box 330, Marks, MS 38646. Call collect (601) 326-8031.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

ASSOCIATES or physicians interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Situations Wanted

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

FAMILY PRACTITIONER, PEDIATRICIAN and INTERNIST

Needed to staff three-doctor and one dentist (committed) medical clinic to be built by individuals in Hokes Bluff, AL. Completion date: July 1980.

Residential community of 3,500 population (15,000 in trade area, adjoining Gadsden, AL — population of 60,000). Two modern hospitals (600 beds). Both have 24-hour ER coverage. Over 1,400 in local schools — 3A sports. Jr. college and four year college nearby. This is not a poverty area and does not qualify for government grants, etc. Less than 5% Medicaid patients. Workers have good income, mostly from Gadsden Industries. Area is highly insurance oriented on both prescription drugs and medical services. No doctors here at present. Last one left due to overwork.

Contact: Scott Godfrey, R.Ph. or Bill Street, R.Ph.

Rt. 7, Box 459

Gadsden, AL 35903

(205) 492-3521 or

(205) 492-4238 (Street residence)

CLASSIFIED

POSITIONS AVAILABLE IMMEDIATELY. The Jackson VA Medical Center is hiring physicians to work in the Admission Office. Primary care specialties (internal medicine, family practice, general practice, emergency medicine) will be given priority. Valid medical license in any state required. Regular hours, competitive salary, and liberal fringe benefits make this a particularly attractive position. Address inquiries to: William A. Causey, M.D., Chief, Medical Service, VA Medical Center, Jackson, MS 39216. Telephone (601) 362-4471, ext. 1841.

Watch for the
Complete Annual
Session Program in
the April Issue
of the Journal MSMA

Index to Advertisers

Burroughs Wellcome	60D, 64A	Mississippi Stationery	10
Canton Exchange Bank	66	Parke, Davis and Company	17
Citizens Bank	8	Premier Printing	14
Coca-Cola	4		
Fenwick Hall	7	Riverside Hospital	12
Godfrey & Street	19	Roche Laboratories	second, third and fourth covers
Harrel Chevrolet-Oldsmobile	10	William H. Rorer, Inc.	10A, 10B, 10C, 10D
Janssen Pharmaceuticals	62, 63		
Eli Lilly and Company	18	Smith Kline Diagnostics	14A
Merck Sharp & Dohme	64B, 64C, 64D	Smith, Kline & French	6B
Merrell-National, Inc.	6, 6A, 14B, 15, 16, 60, 60A		
Mississippi Medical Fraternal and Educational Society	3	The Upjohn Company	60B, 60C, 60D
		Veterans Administration Medical Center	19
		Wyeth Laboratories	56A, 56B, 56C, 56D
		Thomas Yates and Company	17

IN CONCLUSION

AMA's Council on Scientific Affairs has called on doctors to move still more into the forefront of the campaign against tobacco. Those few remaining physicians who continue to smoke are urged by their peers in the AMA to stop. Doctors are urged to further discourage smoking by their patients. Medical societies are urged to initiate more vigorous antismoking efforts. AMA encourages Congress to readjust the cigarette tax, phase in production of less toxic tobacco and make the health warning on cigarette packs more explicit. AMA also requests stricter regulation of tobacco ads by FTC.

In response to the widespread interest in providing patients with detailed information on prescription drugs on the part of legislators, government agencies, consumer groups and health professionals, Roche Laboratories is conducting an in-depth test in three metropolitan areas. The six-month test will evaluate attitudes and responses of physicians, pharmacists and patients to detailed information about Valium therapy. Some of the randomly-selected pharmacies will provide individual patient information sheets and others will offer access to a drug reference book.

A congressional Budget Office study released early this year concludes that inflation in medical costs may worsen because of the federal government's policy of not taxing contributions by employers to worker health insurance programs. The study states that in recent years employers have opted for tax-free fringe benefits, such as improved medical insurance, instead of wage increases, thus driving up costs. The report said the employer exclusion causes a loss of \$9.6 billion in federal revenues each year.

More than 2,000 of the nation's hospitals have designated departments to coordinate patient education activities, almost twice as many as in 1975, findings of a newly released survey of hospital inpatient education indicate. The survey, conducted by the American Hospital Association's Center for Health Promotion, also reported that slightly more than half of the reporting hospitals indicated that they currently are offering health education programs to members of the community, and 674 are offering education services to businesses.

Last month a federal judge issued a permanent injunction forbidding the sale of weiners, frankfurters, bacon or bologna unless it is cured with nitrite to prevent botulism. U.S. District Judge William C. Stuart issued the order rejecting a change in Department of Agriculture labeling regulations, saying that the change could endanger the public. The USDA had sought to permit the sale of nitrite-free products under the traditional names, but with a warning label calling for proper refrigeration. The judge felt the public might ignore the warnings.

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.



Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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10029

Her next attack of cystitis may require the BactrimTM 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *bacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of fecal colonization by fecal uropathogens. It has no significant effect on other normal, necessary intestinal fl

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

April 1980

BALCONY

Journal of the
State Medical
Association

Mississippi

(ISSN 0026-6396)

Contents:

Cystic Lymphangioma

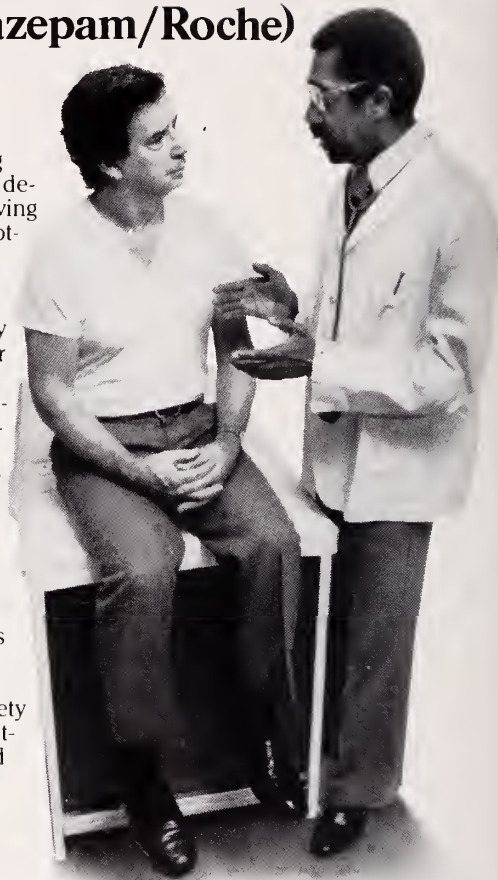
Complete Annual
Session Program



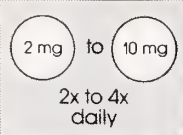

Monitoring patient response to Valium® (diazepam/Roche)

Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST
	

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

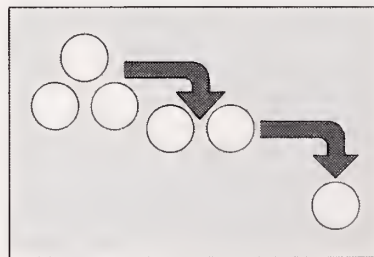
SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention

When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.



2-mg, 5-mg, 10-mg scored tablets
Valium®
diazepam/Roche

An Important Adjunct to Your Treatment
Program for Excessive Anxiety



See the following page for a summary of product information.

Valium® (diazepam/Roche) ®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Medical Leadership Looks Toward 1980's

Challenges and opportunities of the 1980's were examined at the recent AMA 8th National Leadership Conference in Chicago. More than 900 Federation leaders, including MSMA officers and auxiliary members, heard the views of political and economic prognosticators, and exchanged ideas on such problems as membership, community liaison and public relations.

Conference participants set out to achieve what Board of Trustees Chairman Lowell H. Steen, M.D., called "putting interdependence to work as helpfully and effectively as possible . . . on behalf of medical professionalism, organized medicine, and the public."

Three syndicated columnists — John Naisbitt, Robert D. Novak, and Thomas Wicker — gave the conference a preview of the next decade, stressing the shift from centralization in society. Naisbitt said, "We are celebrating diversity, local initiative and regionalism." The political left and right are coming together against federal regulation, he pointed out, but there will be more state regulation and there will be a need for greater leadership at state and local levels.

Two congressmen expressed a similar view of the future. Rep. James R. Jones (D-Okla.) said the trend is toward coalition politics with more bipartisan review of "existing out-of-control programs and limitations on the powers of federal agencies." Coalition politics was evident in the defeat of the Administration's hospital cost containment bill, he said, and bipartisan concern on fiscal policy will rule out both the Kennedy and the Administration's approach to national health insurance. Rep. David Stockman (R-Mich.) predicted a "total revolution in health care policy," with health care returned to the marketplace and away from the federal bureaucracy. The action on hospital cost controls "finally brought thinking people to their senses," he said. "We have to create a market for consumer choice in health care and transform consumers into shoppers."

Out of the past came Wilbur Cohen, former HEW secretary and architect of Social Security, who also called for action at the state level. He suggested more vigorous voluntary efforts by the states to control health care costs, including negotiated fee schedules. The NHI plan that will be adopted has not yet been drafted, he said, and he urged physicians to play a role in its formulation. "One thing we learned from Medicare was that physicians should have had a greater role in its development," he noted.

*Morris E. Chafetz, M.D.,
Founding Director of the National
Institute on Alcohol Abuse and Alcoholism,
is pleased to announce
the opening of a private
residential alcoholism treatment facility
in Charleston, South Carolina.*



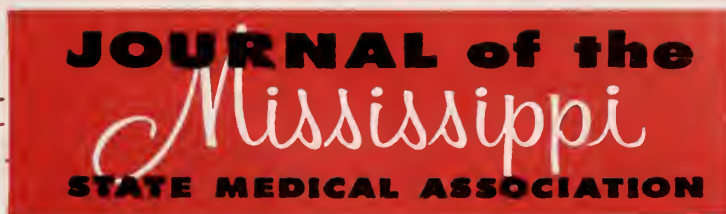
FENWICK HALL

John H. Magill, Executive Director. Layton McCurdy, M.D., Medical Director. Phone 803-559-2461.

Volume XXI

Number 4

April 1980



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CONTENTS

ORIGINAL PAPER

- Radiologic Seminar CCI: **67** RICHARD B. ELLISON, M.D.
Cystic Lymphangioma — Jackson, MS
A Consideration in
Asymptomatic, Massive
Cystic Splenomegaly

SPECIAL ARTICLE

- Complete Program **70** 112th Annual Session

EDITORIAL

- AMA-ERF Needs Your **85** GEORGE H. MARTIN, M.D.
Support Vicksburg, MS

THIS MONTH

- The President Speaking **84** FTC Broadens Its Attack on
Medicine
Practice Management **86** Doctor, Did You Mean What You
Mailbox Said?
Medical Organization **87** Physicians Urged to Report
Pesticide Poisonings
Recollections **92** From the April 1961 Issue of
JOURNAL MSMA

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Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68%*	93%**
Mintezol ¹	35%†	45%††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX[®].

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
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Committed to research...
because so much remains to be done.

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JPI-023



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermox[®] TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
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Tupelo Physicians Address AAMA-MS Symposium

Tupelo physicians Dan L. Brasfield, Joe N. Bailey, III, and Janis Burns were among speakers at the Ninth Annual Educational Symposium sponsored by the American Association of Medical Assistants, Mississippi Society.

Some 75 medical assistants attending the February meeting in Tupelo heard discussions of "Radiology and Diagnostic Imaging Update," by Dr. Brasfield; "Overview of Gastroenterology" by Dr. Bailey; and "A Look at the Field of Plastic Surgery" by Dr. Burns. Mrs. Mary Jo Green, medical office consultant of Memphis, discussed "Inflation in the Medical Office."

Chairman of the symposium, which also included a luncheon and fashion show, was Mrs. Evelyn Wright, AAMA-MS educational chairman.

Medical Assistants Plan Convention

The 14th Annual State Convention of the American Association of Medical Assistants, Mississippi Society, is set for April 18-20, at the Ramada Inn in Natchez. Theme of the convention, hosted by the Homochitto Valley Chapter of the society, is "Pilgrimage to Professionalism."

Featured speaker for the Saturday night banquet will be Senator Bob Montgomery of Canton, who will speak on "Health Legislation."

The Saturday afternoon sessions will include discussions of "Parliamentary Law" and "Coping with Job Stress." The workshops will provide CEU credit.

Special events include a tour of Melrose, a buffet supper with entertainment by "The Medicine Show," and a reception for new state officers. The society's annual business session will be conducted on Saturday morning.

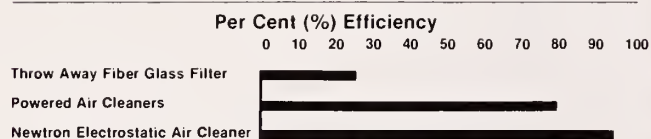
Medical assistants interested in becoming a member of the society are invited to attend. For more information, contact convention chairman Linda Robinson at 442-4893 or society president Marian Cook at 842-8736.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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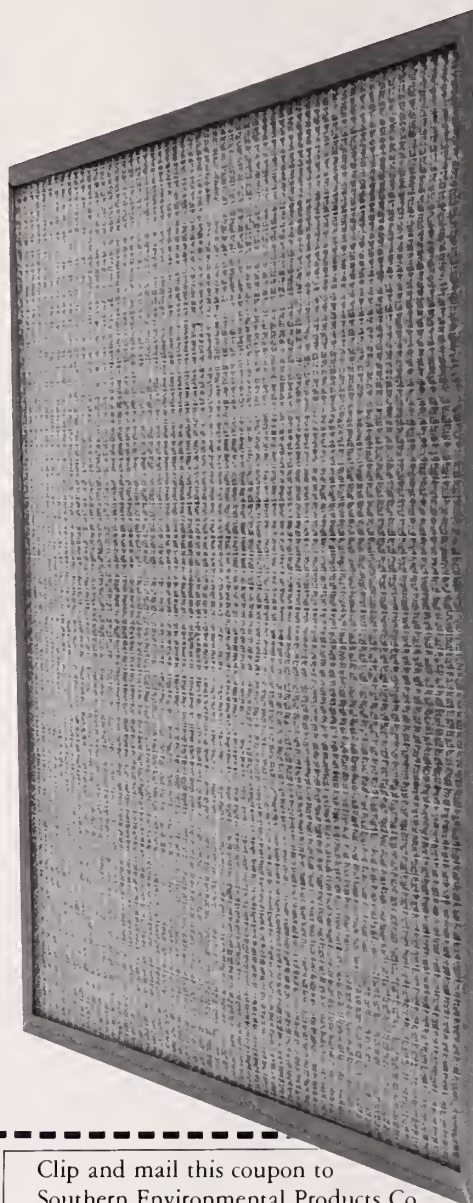
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NEWSLETTER

April 1980

Dear Doctor:

Business can and should do much more to help reduce the rate of increase in health care costs, says an editorial in "Washington Report." The author, active in the Voluntary Effort, is William O. Beers, retired chairman of the board and chief executive officer of Kraft, Inc. He noted that the success of the Voluntary Effort in the past two years "has been primarily due to the work of health care providers," and he listed several actions business can take:

Business executives should determine company health care expenditures for employees; conduct formal utilization reviews and audits of their health benefit programs and change uneconomical patterns; educate employees on seeking health care so that unnecessary services are avoided; and strengthen ties with health care organizations.

The president of the Blues associations has credited physicians with having a significant impact on cost containment without reducing quality of care. He noted in "Medical World News" that in the past 10 years substantial reductions occurred in the number of hospital admissions and length of stay. He remarked that results were better for Blues subscribers than for the general population under 65.

Some 2,000 newspapers throughout the nation recently began receiving a weekly column providing general, lay language information about the most widely used drugs in America. Developed by the U.S. Pharmacopeial Convention, the information series provides both general and specific information about drugs. The stated goal is to answer consumer questions and to stimulate greater communication between doctors and patients.

HEW has established procedures for imposing sanctions against health care providers and practitioners who provide excessive or poor quality care to Medicare and Medicaid patients. The sanctions will be imposed on the basis of reports sent to HEW's Health Care Financing Administration by PSROs. HCFA has the authority to exclude (permanently or temporarily) providers from the programs or to assess fines of up to \$5,000.

The American College of Radiology has strongly rebutted an FDA report which criticized physicians, dentists and x-ray technicians for ordering unnecessary x-rays amounting to an extra \$2 billion and which charged private radiologists with hiring unskilled technicians because of lower pay demands. The report said errors cause repeated exposure and questioned using x-rays as screening procedures.

Sincerely,



Patsy Silver
Managing Editor

Junior League Purchases Newborn Ambulance



Cecile Wardlaw, chairman of the Junior League of Jackson's committee which developed the project to purchase a newborn ambulance for the University of Mississippi Medical Center, gets a tour of the UMC newborn intensive care unit with (from left) Dr. Philip Rhodes, associate professor of pediatrics and newborn center chief, and Dr. Norman C. Nelson, UMC vice chancellor.

Panel Discusses Ob-Gyn Manpower



Former residents and faculty in the obstetrics and gynecology department in the School of Medicine at the University Medical Center held their annual meeting at UMC in February. Dr. Warren Pearse, left, executive director of the American College of Obstetricians and Gynecologists, Dr. Winfred Wiser, center, UMC ob-gyn chairman, and Dr. Michael Newton, the first chairman of the UMC ob-gyn department (1955-1966) and now professor of ob-gyn at Northwestern University School of Medicine, participated in a panel discussion on ob-gyn manpower.

Special Ambulance Boosts Newborn Transport Program

The Junior League of Jackson has purchased a specially equipped ambulance for the University of Mississippi Medical Center's newborn transport program.

The new ambulance, which will be delivered this spring, will be a traveling neonatal intensive care unit, according to Dr. Philip Rhodes, associate professor of pediatrics and newborn center chief. "Our transports doubled last year. The UMC transport team has done an excellent job, but standard ambulances are not designed or equipped for the sick newborn," he added.

The UMC newborn center is the hub of a statewide cooperative program aimed at reducing the state's newborn mortality rate. The UMC newborn center offers 24-hour telephone consultations and transport services.

A contest to give the ambulance a name is open to elementary, junior and high school students. The winning entry will be announced later this month.

Dr. Welch Accepts State Hospital Post

William C. Welch, Jr., M.D., has been appointed Clinical Director of Mississippi State Hospital at Whitfield.

A native of Tupelo, Dr. Welch received his M.D. degree from the University of Mississippi School of Medicine in 1961. He joined the staff of Mississippi State Hospital in May 1979, following completion of a psychiatric residency at University Medical Center.

Formerly engaged in family practice, Dr. Welch also served as assistant director of student health at Mississippi State University.

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Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

* Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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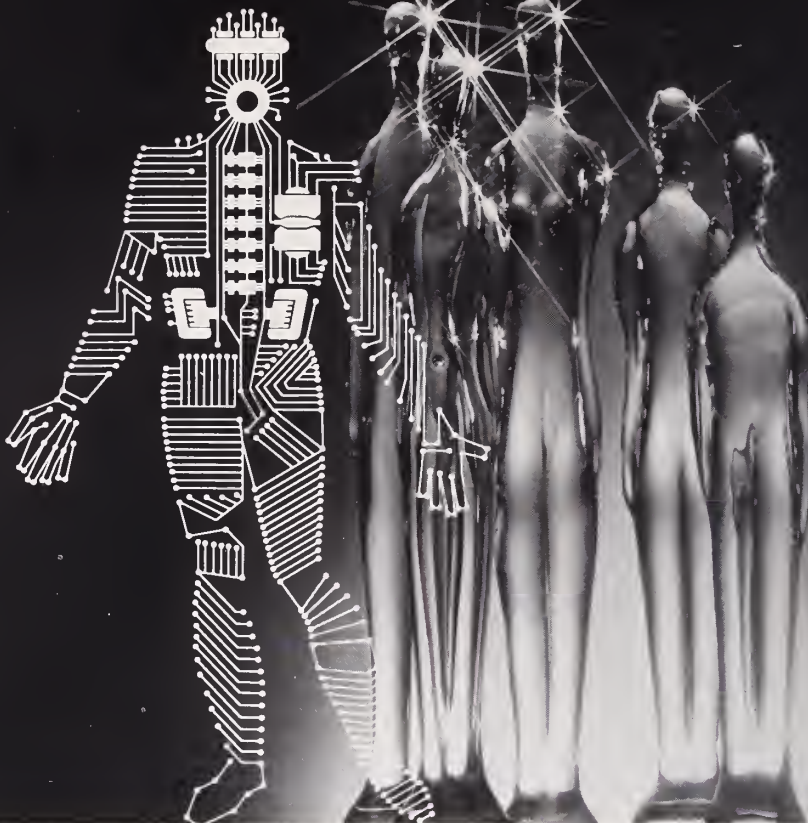
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- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes; nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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Ceremony Honors Medical Leaders

Thirteen Mississippians who held positions of leadership during the Medical Center's formative years will be recognized during a dinner climaxing Continuing Education Day activities April 19.

Governor William Winter, immediate past president of the University of Mississippi Alumni Association, will give the invocation and welcoming remarks. Dr. James C. Griffin of Jackson, president of the Medical Guardian Society which is sponsoring the day, will be master of ceremonies.

The Honorable J. P. Coleman, chief justice of the fifth judicial circuit of the U. S. Court of Appeals, will be both dinner speaker and honored guest.

Judge Coleman began his four-year term as Mississippi's governor just one year after the Medical Center opened its doors in 1955.

Following Judge Coleman's address, Chancellor Fortune and Vice Chancellor Nelson will recognize Dr. Blair E. Batson, professor of pediatrics and department chairman since 1955; Dr. Warren N. Bell, professor of clinical laboratory sciences and chairman of the department since 1959; Dr. Thomas J. Brooks, Jr., professor of preventive medicine and department chairman since 1952; Judge Coleman; Elizabeth W. Graves, professor emeritus and professor of nursing and director of the program for students with advanced standing from 1959 until her retirement in 1974;

Dr. Arthur C. Guyton, professor of physiology and biophysics and chairman of the department since 1948; Dr. James D. Hardy, professor of surgery and department chairman since 1955;

Dr. David S. Pandratz, School of Medicine dean emeritus, who became dean of the two-year medical school in 1946 and served as first dean of the four-year school and director of the Medical Center until his retirement in 1960; Dr. Charles C. Randall, professor emeritus and professor of microbiology and chairman of the department from 1957 until his retirement in 1978; Dr. Robert D. Sloan, professor of radiology and chairman of the department since 1955;

Dr. Louis L. Sulya, professor emeritus and professor of biochemistry and chairman of the department from 1955 until his retirement in 1977; Dr. John D. Williams, chancellor emeritus and Ole Miss chancellor from 1946 until his retirement in 1968; and Dr. David B. Wilson, director of University Hospital from 1955-1969 and assistant vice chancellor for special projects and health planning until his retirement in 1978.

Review A Book

The following books have been received by the MSMA Headquarters Office. Medical readers (members of MSMA) interested in reviewing any of these volumes should address their requests to Editor, THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, P. O. Box 5229, Jackson 39216. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to the JOURNAL a review for publication.

Correlative Neuroanatomy and Functional Neurology: Seventeenth Edition. By Joseph G. Chusid, M.D. Los Altos: Lange Medical Publications, 1979.

Review of Medical Physiology: Ninth Edition. By W. F. Ganong, M.D. Los Altos: Lange Medical Publications, 1979.

Review of Physiological Chemistry: Seventeenth Edition. By H. A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D. Los Altos: Lange Medical Publications, 1979. \$14.50.

Clinical Cardiology: Second Edition. By Maurice Sokolow, M.D., and Malcolm B. McIlroy, M.D. Los Altos: Lange Medical Publications, 1979. \$17.50.

Handbook of Institutional Pharmacy. By Mickey C. Smith, Ph.D., and Thomas R. Brown, Pharm. D. Baltimore: Williams & Wilkins, 1979. \$27.95.

Review of Allied Health Education. By Joseph Hamburg. University Press of Kentucky, 1979. \$7.50.

The Truth About Senility - And How to Avoid It. By Lawrence Galton. New York: T. Y. Crowell, 1979. \$9.95.

What You Should Know About Medical Lab Tests. By Bernard Kliman, M.D., and Raymond Vermett. New York: T. Y. Crowell, 1979. \$9.95.

The Courage to Live. By Ari Kiev, M.D. New York: T. Y. Crowell, 1979. \$7.95.

Vitamin C Against Cancer. By H. L. Newbold, M.D. New York: Stein and Day, 1979. \$10.95.

Handbook of Pediatrics. By Henry K. Silver, M.D.; C. Henry Kempe, M.D.; and Henry B. Bruyn, M.D. Los Altos, CA: Lange Medical Publications, 1980. \$9.50.

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DATELINE

Chiropractors Object To Screening Method Pascagoula, MS - Two Gulf Coast chiropractors have objected to a scoliosis screening program on the grounds that school health nurses are not qualified. In letters to the editor of the "Mississippi Press" one stated that "chiropractors are the only recognized spinal experts" and that spinal problems such as scoliosis "should be left to these experts," and the other said the public "is entitled to know the truth of alternate medical methods" and was dismayed at the "dark age of allopathic medical awareness."

Ethical Guidelines Reviewed Chicago, IL - In the new edition of Judicial Council Opinions and Reports, the AMA council states, "While physicians should be conscious of costs and should not provide or prescribe unnecessary services or unnecessary ancillary facilities, concern for the patient and the quality of care the patient receives comes first." The booklet also contains new ethical standards on in vitro fertilization, euthanasia, and patient confidentiality. Copies are \$2 each, from AMA Order Dept., Box 821, Monroe, WI.

Corneal Transplant Causes Rabies Boise, ID - The first case of rabies acquired from a tissue transplant was documented recently when a 37-year-old Boise, Idaho woman died of rabies. She had received a corneal transplant seven weeks earlier from a 39-year-old man who had died of presumed Guillain-Barre Syndrome. Fluorescent antibody studies confirmed the diagnosis in the recipient and in the donor. The case has raised suggestions that criteria for accepting donors be reevaluated.

Diphtheria Fatality Is Reported Jackson, MS - In reporting the death from diphtheria of a 5-year-old California boy, Dr. Durward Blakey of the Mississippi Bureau of Disease Control, reminds that suspicion of diphtheria warrants prompt treatment with antitoxin as well as antibiotics. In this case, ampicillin was started after a provisional diagnosis of infectious mononucleosis. (The child had attended school on a "personal exemption" from immunization because his father, a chiropractor, did not believe in immunization.)

Carcinogens List Criticized New York, NY - The American Industrial Health Council has urged federal agencies to reconsider "generic" regulations of carcinogens and urged them to assure the public that the thousands of weak "signals" don't represent danger in normal situations. They note that increased "signals" are due to improved testing methods and do not reflect cancer increases. He said the list of suspected carcinogens (now including peanut butter and black pepper) grows at the rate of 300-400 per year, alarming the public.

Physician Lectures Highlight Continuing Education Day

Three University of Mississippi Medical Center department chairmen will address state physicians as part of UMC Continuing Education Day April 19 in Jackson.

The event, which also will mark the Medical Center's near quarter century of service to the state, is sponsored by the Medical Alumni Guardian Society of the University of Mississippi Alumni Association.

The April 19 morning sessions, on the UMC campus, will feature lectures by Department of Medicine chairman Dr. Harper Hellems and Department of Surgery chairman Dr. James D. Hardy.

Dr. Hellems, whose topic is "Education, Research and Patient Care," served a three-year term as American College of Cardiology governor for Mississippi. He was twice a faculty member on the college's circuit courses in Thailand, Singapore, Malaysia, Nigeria and The Sudan, Africa. Recipient

of the Theodore and Susan Cummings Award of the American College of Cardiology, he has been department chairman at UMC since 1965.

"Organ Replacement: Six Mississippi Firsts" is Dr. Hardy's lecture topic. Department chairman since 1955, he is currently president-elect of the American College of Surgeons and president of the International Society of Surgery. He is past president of the American Surgical Association, the Society of Surgery Chairman and the Southern Surgical Association.

Dr. Arthur Guyton, UMC professor of physiology and biophysics and chairman of the department since 1948, will give the afternoon address on "Historical and Modern Development of Cardiovascular Control Concepts."

Dr. Guyton is past president of both the American Physiological Society and the Federated Societies of Experimental Biology. In 1979, he was awarded the Founders Medal of the Southern Society for Clinical Research. On the 400th anniversary of William Harvey's birth in 1978, he was invited to give the Harvey Lecture by the Royal College of Physicians in London.

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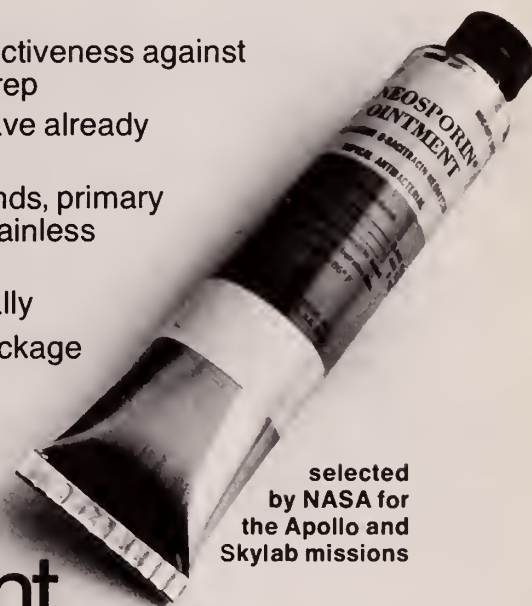
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

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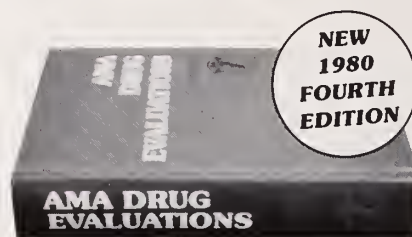
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VE Coalition Adopts 1980 Goals

The National Steering Committee for the Voluntary Effort to Contain Health Care Costs (VE) has adopted goals and objectives for 1980 and beyond. Besides setting specific challenges for each sector of the health care field, the coalition has enlarged the scope of the VE. Business, consumers, labor and government are being asked to undertake new or expand existing efforts and initiatives toward cost containment.

The NSC commended the achievements by hospitals, physicians, health insurers and others, noting that the aggressive voluntary effort resulted in a savings during the first two years of more than \$3 billion in hospital costs alone. The committee remarked that the health care field has achieved credibility regarding both its commitment and its ability to contain health care costs and maintained that initial skepticism by the press has been substantially eliminated. The committee noted that the U.S. House of Representatives expressed great confidence in the VE when, last November, it passed a bill providing for continued voluntary efforts to contain hospital costs instead of the President's proposal for a mandatory, government regulated hospital cost containment program.

The AMA has reaffirmed its commitment to the VE. Executive Vice President Dr. James H. Sammons stated, "... the effort must continue, not only to show that our dedication to cost-effective care is not a short-term response to the threat of regulation but also because it is in the best interest of our patients. We urge that you continue and intensify the medical profession's role in the VE, and that you encourage the increased community involvement proposed in the 1980 goal statement."

The goal statement endorses AMA's policy of advocating that physicians, during the first half of 1980, continue to voluntarily restrain their fee increases to a level that maintains the 1979 relationship between the All-Items Index and the Physician's Service Index of the CPI.

Besides setting specific goals for hospitals regarding inpatient expenditures, number of beds, productivity and utilization review, the goal statement calls for continuing efforts toward including cost-effectiveness and cost containment education programs in graduate, postgraduate and continuing education curricula.

Manufacturers and suppliers are asked to independently exercise restraint in their pricing policies.

Insurance carriers, other purchasers of care (pub-

lic and private), business, and organized labor are asked to examine cost-effective alternatives to existing health insurance programs, including consumer cost sharing and other approaches. New benefits or expansion of existing benefits should be carefully assessed on the basis of their cost-effectiveness and inflationary impact. Insurance carriers are encouraged to continue and to expand activities to assist hospitals, physicians and others in containing costs.

Commenting that legislation, regulations and administrative procedures have in many instances contributed adversely to rising health care costs, the goal statement calls for HEW and other national and state agencies, along with insurance carriers, to decelerate their administrative cost increases in carrying out their activities. Proposed health care legislation and regulations should be analyzed as to cost-effectiveness and inflationary impact before being initiated.

All participants in the VE are urged to develop, implement, and evaluate programs at the community level aimed at promoting increased responsibility on the part of the individual consumer for his or her own health, and for helping to reduce or eliminate the individual consumer's potential health risks.

A final objective is that a program of public education be undertaken at all levels to explain to the public the progress that the health care field is making in restraining cost increases through voluntary action. The public education program should include ways to actively include consumers, business, labor and others in voluntary cost containment efforts, and to improve public understanding of the reasons why health care costs are increasing.

The National Steering Committee will monitor progress toward achievement of each of the goals and will release results as they become available.

MSMA Tennis Tournament and Golf Tournament

Tuesday Afternoon

112th Annual Session

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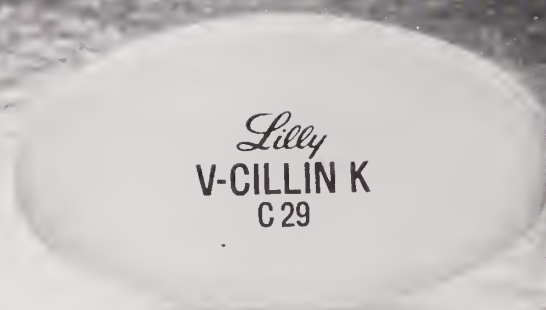
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ORIGINAL PAPERS

Radiologic Seminar CCl: Cystic Lymphangioma — A Consideration in Asymptomatic, Massive, Cystic Splenomegaly

RICHARD B. ELLISON, M.D.

Jackson, Mississippi

LYMPHANGIOMA of the spleen is generally considered relatively uncommon since the spleen is the least common intra-abdominal site of cystic disease.¹ Cystic disease of the spleen is likely to be encountered more often than one might expect however, since cystic tumors in general are less likely to be reported in the medical literature than solid tumors, possibly because cystic tumors are usually benign and their cellular origin is obvious.²

A preoperative differential diagnosis of asymptomatic, cystic splenomegaly must include congenital splenic cysts, post traumatic or post inflammatory cysts, splenic hemangioma, parasitic cysts, hamartoma and lymphangioma.

Neoplastic diseases producing splenomegaly may resemble a benign cystic disease of the spleen on one or more diagnostic modality images, but the combination of radionuclide liver-spleen scans, angiography, ultrasound, and (if indicated) computed tomography, should provide a reasonably accurate preoperative diagnosis. Benign hamartomas and hemangiomas generally show rich vascularity at angiography, often with neovascularity resembling malignant disease. Metastatic disease foci may be relatively avascular but more often show tumor

neovascularity as well as presenting as solid or partially necrotic masses on ultrasound or computed tomography. Infiltrative diseases such as leukemia, lymphoma and the reticuloses plus multiple abscesses or infarcts may cause narrowing and stretching of intrasplenic vessels, producing multiple zones of avascularity at angiography. These diseases should



Figure 1. The typical "swiss cheese" pattern of the radionuclide spleen scan (arrows).

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic Hospital,
Jackson, MS.

only rarely present a diagnostic problem, however, when clinical findings, history and evidence of multisystem disease are considered.³

The radionuclide liver-spleen scan in cystic lymphangioma of the spleen generally produces a "swiss cheese" type pattern within the enlarged spleen and a normal liver display. The arterial phase of an angiogram can be expected to show intrasplenic arterial branches stretched and splayed throughout the parenchyma but with no pathologic vessels demonstrated. The parenchymal phase shows compressed zones of splenic parenchyma with multiple lucencies corresponding to the avascular cysts. The spleen is relatively hypovascular and the splenic artery and vein are normal in size.³

The computed tomogram, in the case from which the illustrations are taken, indicated a cystic process but did not demonstrate a demarcation between the left lobe of the liver and the spleen. The radionuclide



Figure 2. Arterial phase of angiogram showing stretched and splayed intra-splenic arteries (open arrows).



Figure 3. Parenchymal phase of angiogram showing compressed splenic parenchyma and cystic lucencies.



Figure 4. Computed tomogram scan showing enlarged, cystic spleen (dark arrows) and displaced, contrast filled stomach (open arrows).

scan strongly suggested cystic or neoplastic disease confined to the spleen. Angiography confirmed that the disease process involved only the spleen (see Figures 1-4). Surgery and pathology revealed a 1390 gram, 20cm x 15cm x 9cm spleen with no gross involvement of other abdominal organs. A pathological diagnosis of cystic lymphangioma of the spleen was subsequently made.

Such endothelial-lined, cystic lymphangiomas are closely kin to the well known cystic hygroma of soft tissue. The pathogenesis of cystic lymphangioma is believed to be congenital blockage of lymphatic flow, leading to cystic dilatation of splenic lymph channels.⁴ Surgical removal of the spleen is curative.

Summary

An instance of cystic lymphangioma producing massive, asymptomatic splenomegaly is presented with illustrations of the appearance of the disease process on radionuclide scans, computed tomograms and angiograms. Cystic lymphangioma of the spleen is similar to cystic hygroma in soft tissues, is congenital in origin, and is curable by splenectomy. The entity should be considered as a possible cause of splenomegaly when cystic zones of avascularity are demonstrated. ★★★

969 Lakeland Drive (39216)

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3. Shanser, J. D., Moss, A. A., Clark, R. E. and Palubinskas, A. J.: Angiographic evaluation of cystic lesions of the spleen: Am. J. Roentgenol. & Rad. Therapy 119:166-174, 1973.
4. Pearl, G. S. and Nassar, V. H.: Cystic lymphangioma of the spleen: S. Med. J. 72(6):667-669, 1979.

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112th Annual Session

Mississippi State Medical Association

April 27-May 1

Biloxi

Finalized plans for the association's 112th Annual Session reveal a full schedule of activities which will take place when the session gets underway on Mississippi's sunny Gulf Coast April 27, 1980. Host hotel is the Biloxi Hilton.

The five-day meet will feature programs conducted by 14 scientific sections, meetings of specialty societies, technical and scientific exhibits, meetings of the House of Delegates, and four special seminars. Additionally, various medical-related groups have scheduled meetings, and two medical alumni societies have announced plans for reunions.



Completing the list of activities are the annual tennis tournament, a golf tournament, and numerous social occasions.

Dr. J. Elmer Nix, chairman of the Council on Scientific Assembly, announces that many outstanding speakers will participate in the Scientific Program which opens on Sunday and continues through Wednesday. The Scientific Program is accredited for 9 hours Category 1 credit toward the AMA Physician's Recognition Award. Also nine hours of credit have been approved by the American Academy of Family Physicians.

Several scientific sections have collaborated on plans for continuing medical education sessions. The first day's scientific program will combine the Sections on Anesthesiology, EENT, Radiology, Orthopedic Surgery and Surgery. The three-hour scientific program slated for Tuesday, April 29, has been planned by representatives of the Sections on Family Practice, Urology, Ob-Gyn, Pediatrics and Psychiatry. Wednesday's scientific program will feature courses scheduled by Sections on Pathology, Medicine, Dermatology and Preventive Medicine.

The House of Delegates, meeting initially on Monday morning, will hear an address by Dr. Gerald P. Gable, MSMA president. House speaker Dr. R. Faser Triplett of Jackson and vice speaker Dr. Walter H. Rose of Indianola announce that delegates will receive their complete House of Delegates folders prior to the convention.

Principal speaker for the annual session is Dr. Thomas E. Nesbitt of Nashville, TN, immediate past-president of the AMA. He is slated to address the opening meeting of the House of Delegates. The final meeting of the House on Thursday will see the completion of association business.

A special address by ABC news commentator Howard K. Smith will highlight the MSMA membership banquet on Wednesday night.

Clinic Managers Association will sponsor a practice management seminar on Wednesday morning. Also on Wednesday morning will be a seminar on "Diseases of the Pancreas" sponsored by the Mississippi Society for Gastroenterology.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 112th Annual Session of the Mississippi State Medical Association is called to meet at Biloxi, Mississippi, on Sunday, April 27, 1980, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9:30 a.m. in the morning at the Biloxi Hilton on April 28.

The Scientific Assembly consisting of the 14 Scientific Sections, will meet during April 27-30, 1980.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

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CARL G. EVERS, Jackson	1978-79

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located on First Level near the Grand Ballroom. No person may be admitted to any activity of the annual session without first registering. **There will be a registration fee of \$75.00 for nonmember physicians except interns and residents.** Hours of registration will be: 8:00 a.m.-3:00 p.m., Sunday; 8:00 a.m.-4:30 p.m., Monday, Tuesday and Wednesday; and 8:00-9:00 a.m., Thursday.

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ACTIVITIES CALENDAR

SUNDAY, APRIL 27

7:30 a.m.	Academy of Facial Plastic and Reconstructive Surgery Breakfast and Program	Pacific
	Miss. Chapter, American College of Surgeons Officers Breakfast	Caribbean
9:00	(Sections on Anesthesiology, EENT, Orthopedic Surgery, Surgery, Radiology)	Emerald
12:00 noon	Miss. EENT Association Luncheon	Sands
	Miss. Orthopedic Society Luncheon	Pacific
12:15 p.m.	Miss. Chapter, American College of Surgeons Luncheon	Dunes
	Miss. Society of Anesthesiology Luncheon	Caribbean
	Miss. Radiological Society Luncheon	Atlanta
1:00	Miss. Chapter, American College of Surgeons Meeting	Emerald
3:30	Miss. Medical Fraternal and Educational Society, Inc. Annual Membership Meeting	Emerald
5:30	MSMA President's Reception	Stardust Sands & Dunes

MONDAY, APRIL 28

7:30 a.m.	Ole Miss Alumni Association Past Presidents' Breakfast	Stardust
8:00	MSMA Reference Committee Breakfast	Atlantic
	Auxiliary Finance Committee	Pacific
9:30	MSMA House of Delegates	Emerald
11:00	Auxiliary Board Meeting	Caribbean
12:00-5:00 p.m.	Film Series — "Whatever Happened To the Human Race?"	Room 102
1:00	Miss. Foundation for Medical Care Annual Membership Meeting	Emerald

2:00	MSMA Reference Committee on Reports of Officers, Board of Trustees, and Councils	Emerald
3:30	MSMA Reference Committee on Constitution and Bylaws	Atlantic
5:30	Miss. Foundation for Medical Care Board of Directors Meeting	Stardust
6:00	Tulane Medical Alumni Reception	Pacific
	Arkansas Medical Alumni Reception	Caribbean
	Ole Miss Medical Alumni Poolside Jamboree	Royal D'Iberville

TUESDAY, APRIL 29

7:30 a.m.	Miss. Ob-Gyn Society Education and Advisory Committee Meeting	Pacific
	MSMA Jail Health Committee Breakfast	Sands
	MSMA Past Presidents Breakfast	Atlantic
	The Mississippi Chapter, Association of American Physicians and Surgeons Breakfast Meeting	Dunes
8:00	Auxiliary Officers Orientation Coffee	Caribbean
8:30	Ole Miss Alumni Breakfast	Stardust
9:00	Auxiliary General Session	Grand Casino
	MSMA Scientific Meeting (Sections on Family Practice, Ob-Gyn, Pediatrics, Psychiatry, and Urology)	Emerald
12:00 noon	Miss. Chapter, American Academy of Pediatrics Luncheon Meeting and Program	Stardust
	Miss. Ob-Gyn Society Luncheon	Atlantic
	Miss. Urological Society Luncheon Meeting and Program	Pacific
	Film Series — "Whatever Happened to the Human Race?"	Room 102
12:15	Miss. Chapter, American Academy of Family Physicians Luncheon and Program	Sands & Dunes
12:30	Auxiliary Luncheon	Grand Casino

1:00	Golf Tournament	
1:30	Miss. Perinatal Association Meeting	Caribbean
2:00	Tennis Tournament	
3:00	Auxiliary Board Meeting	Atlantic
5:00-7:00	Miss. Urological Society Cocktails and Program	Caribbean

WEDNESDAY, APRIL 30

7:30 a.m.	Miss. Society of Gastroenterology Breakfast Seminar	Atlantic
	Clinic Managers Association Practice Management Seminar	Stardust
	Auxiliary "Coffee with Binny"	Dunes
9:00	MSMA Scientific Meeting (Sections on Dermatology, Pathology, Medicine and Preventive Medicine)	Emerald
9:30	Auxiliary Gemologist Show	Dunes
11:00	MSMA Nominating Committee	Atlantic
12:00 noon	Miss. Society of Internal Medicine Luncheon	Stardust
	Miss. Association of Pathologists Luncheon	Pacific
	Flying Physicians Association Luncheon	Caribbean
	Film Series	Room 102
12:30	MSMA Fifty Year Club Luncheon	Emerald
	Auxiliary Past Presidents Luncheon	Dunes
1:00	Miss. Society of Gastroenterology Meeting and Program	Sands
6:30	MSMA Membership and Auxiliary Banquet	Versailles Room Royal D'Iberville

THURSDAY, MAY 1

9:00 a.m.	MSMA House of Delegates	Emerald
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EXECUTIVE BUSINESS



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Speaker
R. Faser Triplett
Jackson



DR. ROSE

Vice Speaker
Walter H. Rose
Indianola

HOUSE OF DELEGATES
April 28, 1980
9:30 a.m.
Emerald Room



DR. NESBITT

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the Speaker will announce the order of business. An open meeting on April 28, to which all MSMA members and Auxiliary members are invited, will feature addresses by Dr. Gerald P. Gable, the president of MSMA and Dr. Thomas E. Nesbitt, immediate past president of the American Medical Association. The adjourned meeting of the House will convene at 9:00 a.m. on May 1.

REFERENCE COMMITTEES

Reports of Officers, Trustees and Councils, April 28, 2:00 p.m., Emerald Room
Constitution and By-Laws, April 28, 3:30 p.m., Atlantic
Nominating Committee, April 30, 11:00 a.m., Atlantic

SCIENTIFIC ASSEMBLY

Program is acceptable for 9 prescribed hours by the American Academy of Family Physicians and 9 hours Category I credit toward the AMA Physician's Recognition Award.

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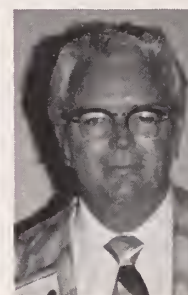
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SCIENTIFIC PROGRAMS

Sections on Radiology, EENT, Anesthesiology, Surgery and Orthopedic Surgery

Sunday, April 27
Emerald Room

9:00 "The Management of Pain and Therapy in Cancer"

Irvin Fleming, associate professor of surgery, University of Tennessee Medical Unit, Memphis.

10:15 "Management of Low Back Pain"

George Wharton, Jackson, MS.

10:30 "Causalgia Pain and Post-Herpetic Pain Relief"

Allan Stallings, Jackson, MS.

11:00 Panel Discussion: George Wharton, George V. Smith and Anupam Routh, Jackson, MS, Larry Day, Hattiesburg, MS and Irvin Fleming, Memphis.

Sections on Family Practice, Urology, Ob-Gyn, Pediatrics and Psychiatry

Tuesday, April 29
Emerald Room

9:00 "Update on Breast Cancer"

Lessa Phillips, Department of Family Practice, University Medical Center, Jackson

9:45 "Advances in Medical Genetics"

John Jackson, Department of Preventive Medicine, University Medical Center, Jackson, MS.

10:45 "Death and Dying"

11:15 Question and Answer Period

Sections on Pathology, Medicine, Dermatology and Preventive Medicine

Wednesday, April 30
Emerald Room

9:00 "Tuberculosis — Still a Serious Problem"

Laurence S. Farer, Director of Tuberculosis Control Division, Center for Disease Control, Atlanta

9:45 "The Hepatic Manifestations of Anti-Tuberculosis Treatment and Other Aspects of TB in the Liver"

Burton Combes, professor of medicine, University of Texas Health Science Center and head of the Division of Liver Disease, Parkland Hospital, Dallas, TX.

10:45 Mini-Talk

Betty Jane Phillips, Ph.D., Director of Clinical Laboratory, Mississippi State Board of Health, Jackson

11:00 Mini-Talk

Guy Campbell, Jackson, MS.

11:15 Panel Discussion

GUEST ESSAYISTS



BURTON COMBES
Dallas, TX



LAURENCE FARER
Atlanta, GA



IRVIN FLEMING
Memphis, TN

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations and major medical institutions will present the Scientific Exhibit. Physicians are eligible for the Aesculapius Awards given for excellence of presentation, quality of content, and originality.

EXHIBITS AND AUTHORS

Surgical Management of Ventricular Aneurysms

Martin H. McMullan and T. L. Kilgore, Jr.,
Surgical Clinic, Jackson, MS.

The University Medical Center Combined Hand Service

Alan E. Freeland and Frederick R. Heckler,
University Medical Center, Department of
Orthopedic Surgery and Plastic Surgery, Jackson,
MS.

Cardiac Surgery — Operative Results in Patients Over 65 Years of Age

James L. Crosthwait, Quinton H. Dickerson,
T. B. Ellis, James C. Hayes, Jeff F.
Hollingsworth, W. Arthur Jones, George K.
McMullan, Thomas D. Paine, William H.
Rosenblatt, McKamy Smith, Malcolm P. Taylor,
Henry B. Tyler, Mississippi Heart Institute-St.
Dominic-Jackson Memorial Hospital, Jackson,
MS.

Establishing a Low Back School

Edward A. Attix and Jackie Nichols, Hattiesburg,
MS.

Endoscopic Laser Coagulation of Gastrointestinal Bleeding

James H. Johnston, Jackson, MS.

Carotid Siphon Stenosis

Seshadri Raju, Buddy Williamson, James D.
Hardy, Department of Surgery and Doppler
Laboratory, University Medical Center, Jackson,
MS.

Hospice Update 1980

Edward M. Lowicki, Jackson, MS.

Therapy of Pediatric Brain Tumor

Robert A. Sanford, University Medical Center,
Department of Neurosurgery, Jackson, MS.

Care for Rheumatoid Arthritic Hands

Somprasong Songcharoen, Suthin Songcharoen
and Frederick R. Heckler, Jackson, MS.

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1980 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies or

equipment, and in providing varied services, will present the exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The technical exhibit is located in the Crystal and Topaz Rooms.

EXHIBITORS

Bedsole Surgical Supply Co., Mobile, AL
Berlex Laboratories, Inc., Cedar Knolls, NJ
Blue Cross & Blue Shield of MS, Inc., Jackson, MS
Boots Pharmaceuticals, Inc., Shreveport, LA
CIBA Pharmaceutical Company, Atlanta, GA
Commerce General Corp., Jackson, MS
Cutter Medical, Division of Cutter Laboratories,
Berkeley, CA
Data Enterprises, Inc., McComb, MS
Data Professional Corp., Jackson, MS
Deposit Guaranty National Bank, Jackson, MS
Disability Determination Services, Jackson, MS
Dista Products Company, Indianapolis, IN
Dome Laboratories, West Haven, CN
Encyclopaedia Britannica, Inc., Chicago, IL
Family Health Services, Jackson, MS
First National Bank, Jackson, MS
General Medical, Jackson, MS
Glaxo, Inc., Ft. Lauderdale, FL
Grolier Interstate (The Americana), Palm Beach
Gardens, FL
Healthco/MS Surgical, Jackson, MS
Hoechst-Roussel Pharmaceuticals, Inc.,
Somerville, NJ
Kremser-Urban Company, Milwaukee, WI
Mead Johnson Pharmaceutical Division, Evansville,
IN
McNeil Laboratories, Ft. Washington, PA
Mississippi Home Health Association, Hattiesburg,
MS
Mississippi Medical Fraternal & Educational
Society, Jackson, MS
Navy Recruiting, Memphis, TN
Niagra Therapy, Kenner, LA
Pennwalt RX Division, Rochester, NY
Pfizer Laboratories, Doraville, GA
Physicians Planning Associates, Gulfport, MS
A. H. Robins Company, Richmond, VA
Sandoz Pharmaceuticals, E. Hanover, NJ
W. B. Saunders Company, Birmingham, AL
Specialty Surgical Instrumentation, Inc., Nashville,
TN
Smith Kline & French Laboratories, Philadelphia,
PA
South Central Bell, Jackson, MS

St. Paul Fire & Marine Insurance Co., St. Paul, MN
Systemedics, Laurel, MS
The Travelers Insurance Co., Jackson, MS
Tutag Pharmaceuticals, Inc., Broomfield, CO
UAD Laboratories, Inc., Minden, LA
U. S. Army, Washington, DC
Weight Watchers in Greater Mississippi, Jackson, MS
Wyeth Laboratories, Philadelphia, PA

SCIENTIFIC GRANTS

Abbott Pharmaceutical Products, North Chicago, IL
Dow Pharmaceuticals
Eli Lilly & Company, Indianapolis, IN
Geigy Pharmaceuticals, Decatur, GA
Merck Sharp & Dohme, Arlington, TX
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Smith Kline & French Laboratories, Philadelphia, PA
The Upjohn Company, Kalamazoo, MI

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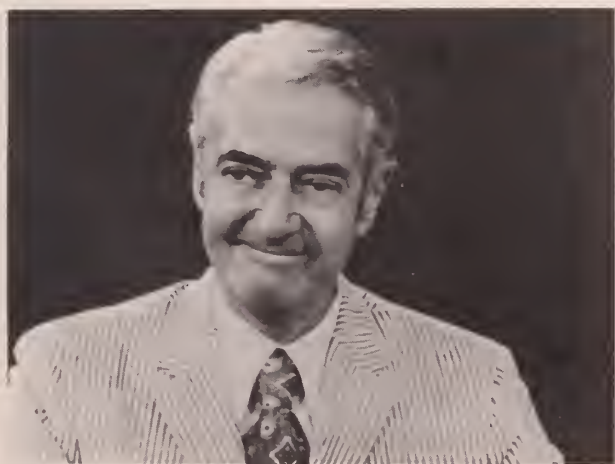
— President's Reception—

Blue Cross and Blue Shield of Mississippi

— MSMA Membership Banquet —
featuring Howard K. Smith

First Mississippi National Bank

(Cocktail hour entertainment sponsored by
Brookhaven Bank and Trust Company)



HOWARD K. SMITH

SUNDAY, APRIL 27, 1980

ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

The Academy of Facial Plastic and Reconstructive Surgery will host a breakfast on Sunday, April 27, at 7:30 a.m. in the Pacific Room. Officers of the academy are: W. Joe Burnett, Oxford, president; Will K. Austin, Jr., McComb, vice president; and J. George Smith, Jackson, secretary.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGY

The Mississippi Society of Anesthesiology will host a luncheon meeting on Sunday, April 27 at 12:15 p.m. in the Caribbean Room. T. Homer Horton of Tupelo is president and Betty M. Bailey of Biloxi is secretary-treasurer.

MISSISSIPPI EENT ASSOCIATION

The Mississippi EENT Association will hold a luncheon and business session on Sunday, April 27, at 12:00 noon in the Sands Room. Association officers are: Fred L. McMillan, Jackson, president; Myron Lockey, Jackson, president-elect; and Wilson E. Moak, Jackson, secretary-treasurer.

MISSISSIPPI ORTHOPEDIC SOCIETY

The Mississippi Orthopedic Society will host a luncheon meeting on Sunday, April 27, at 12:00 noon, in the Pacific Room. Society officers are J. Stewart Williford, Hattiesburg, president; James L. Hughes, Jackson, president-elect; George W. Wharton, Jackson, secretary-treasurer; and Bruce M. McCarthy, Hattiesburg, vice president.

MISSISSIPPI PSYCHIATRIC ASSOCIATION

The Mississippi Psychiatric Association will hold a buffet luncheon meeting on Sunday, April 27, at 12:00 noon, in the Riverside Hospital Hospitality Suite. President is Glen Anderson, Jackson; president-elect is B. Steve Smith of Jackson; and secretary is Julius Collum of Jackson.

MISSISSIPPI RADIOLOGICAL SOCIETY

The Mississippi Radiological Society will host a luncheon meeting on Sunday, April 27, at 12:15 p.m. in the Atlantic Room. Society officers are Kenneth G. Carter, Jackson, president; James T. Trapp, Tupelo, president-elect; and Allen R. Yates, Jackson, secretary.

SUNDAY / Continued

MISSISSIPPI MEDICAL FRATERNAL AND EDUCATIONAL SOCIETY

The Mississippi Medical Fraternal and Educational Society will hold its third annual membership meeting on Sunday, April 27, beginning at 3:30 p.m., in the Emerald Room. C. G. Sutherland of Jackson, chairman of the claims committee, and Walter Epps, Meridian attorney, will speak. All physicians are invited to attend.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The American College of Surgeons, Mississippi Chapter, will conduct a scientific meeting on Sunday, April 27, beginning at 1:00 p.m. in the Emerald Room. Fellows will assemble for luncheon in the Dunes Room at 12:15 p.m. Officers of the college are W. Briggs Hopson, Vicksburg, president; W. Lamar Weems, Jackson, president-elect; and Benton M. Hilbun, Tupelo, secretary. ACS officers will meet for breakfast on Sunday at 7:30 in the Caribbean Room.

PRESIDENT'S RECEPTION

The annual President's Reception for officers, members of MSMA and the Auxiliary and invited guests will be held in the Caribbean Room on Sunday, May 6, from 5:30 to 7:00 p.m.

MONDAY, APRIL 28, 1980

UNIVERSITY OF MISSISSIPPI ALUMNI ASSOCIATION

The University of Mississippi Alumni Association will host a Past Presidents' Breakfast at 7:30 a.m. in the Stardust Room on April 28.

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet at 8:00 a.m. for breakfast and an orientation session on Monday, April 28, in the Atlantic Room. Hosts are R. Faser Triplett of Jackson, speaker, and Walter H. Rose of Indianola, vice speaker.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Monday, April 28,

beginning at 1:00 p.m. in the Emerald Room. All members are urged to attend.

ARKANSAS MEDICAL ALUMNI

Medical graduates of The University of Arkansas will be feted at a reception at 6:00 on Monday evening, April 28, in the Caribbean Room.

TULANE MEDICAL ALUMNI

Medical graduates of Tulane University will be feted at a reception at 6:00 on Monday evening, April 28, in the Sands Room.

OLE MISS MEDICAL ALUMNI

Alumni registration will be located adjacent to MSMA general registration on the First Level Lobby near the Grand Ballroom, and will be open at 8:00 a.m. Tickets for the evening party will be available. A poolside party will be held Monday, April 28 at the Royal D'Iberville Hotel, beginning at 6:00 p.m. A business meeting will be held Tuesday, April 29, beginning at 8:30 a.m. in the Stardust Room at the Biloxi Hilton.

TUESDAY, APRIL 29, 1980

MSMA PAST PRESIDENTS' BREAKFAST

Past Presidents of the Mississippi State Medical Association will enjoy a fraternal breakfast on Tuesday morning, April 29, at 7:30 a.m. in the Atlantic Room. Carl G. Evers of Jackson is host.

MSMA JAIL HEALTH PROJECT ADVISORY COMMITTEE

The MSMA Jail Health Project Advisory Committee will hold a breakfast meeting on Tuesday, April 29, at 7:30 a.m. in the Sands Room.

MISSISSIPPI CHAPTER, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

All physicians are invited to attend a breakfast meeting at 7:30 a.m., Tuesday, April 26 in the Dunes Room. Dr. Albert Cullum, Middleboro, KY, past president of AAPS will speak on "The Medical Practice Contract." Curtis Caine of Jackson is in charge of arrangements.

AMERICAN ACADEMY OF PEDIATRICS, MISSISSIPPI CHAPTER

American Academy of Pediatrics, Mississippi Chapter, will host a luncheon on Tuesday, April

29, at 12:00 noon in the Stardust Room. Officers of the chapter are William F. Sistrunk, Jackson, president, and William M. Hilbun, Tupelo, secretary. John Jackson of Jackson will be the luncheon speaker.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will sponsor a luncheon meeting at 12:15 p.m. on Tuesday, April 29, in the Sands and Dunes Rooms. Guest speaker will be Dr. Wilfred Gillis of Jackson. His topic will be "Residency Training for Family Physicians for Mississippi." Two family medicine residents will give mini-talks, and Dr. Gillis will conclude with an overview of UMC's program. Officers of the Mississippi Academy are Edgar Johnson, Hattiesburg, president; J. Edward Hill, Hollandale, president-elect; Ben E. Kitchens, Iuka, vice president; and Louis Rubenstein, Ocean Springs, secretary-treasurer.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will conduct a luncheon meeting on Tuesday, April 29, in the Atlantic Room at 12:00 noon. Officers of the society are Lewis D. Lipscomb, Jackson, president; Thomas R. Singley, Pascagoula, president-elect; and Earl T. Stubblefield, Jackson, secretary. The Education and Advisory Committee will meet at 7:30 a.m. in the Pacific Room.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will hold a luncheon and business meeting in the Pacific Room, Tuesday, April 29, at 12:00 noon. They will also host a cocktail party from 5:15-7:00 p.m. in the Caribbean Room. Officers of the society are: Lucas O. Platt, Tupelo, president; Stanley Wade, Meridian, president-elect; and Ronald L. Brown, Gulfport, secretary-treasurer.

MISSISSIPPI PERINATAL ASSOCIATION

The Mississippi Perinatal Association will hold its annual meeting on Tuesday, April 19, at 1:30 p.m. in the Caribbean Room. All interested pediatricians and obstetricians are urged to attend. Officers of the association are William L. Kahlstorf, Tupelo, president; Daniel H. Draughn, Jackson, vice-president; and Frank W. Wilburn, Tupelo, secretary-treasurer.

MSMA TENNIS TOURNAMENT

MSMA will sponsor a tennis tournament with men's and women's doubles on Tuesday afternoon, April 29, beginning at 2:00 p.m. Henry Tyler of Jackson is chairman.

MSMA GOLF TOURNAMENT

The golf tournament will begin at 1:00 on Tuesday afternoon, April 29.

WEDNESDAY, APRIL 30

CLINIC MANAGERS ASSOCIATION SEMINAR

All MSMA members are invited to attend a practice management seminar to be conducted by the Mississippi Association of Clinic Managers on Wednesday at 7:30 a.m. in the Stardust Room. A complimentary breakfast of sweet rolls and coffee will be served.

GASTROENTEROLOGY SEMINAR

The Mississippi Society for Gastroenterology will host a breakfast seminar entitled "Diseases of the Pancreas: Diagnosis and Management," on Wednesday, April 30, at 7:30 a.m., in the Atlantic Room. **There will be a \$5.00 registration fee that will cover the breakfast and the seminar.** The meeting is open to all. James Q. Sones, Jackson is society president and William M. McKell, Jr. of Jackson is secretary-treasurer. The society will host a meeting and program at 1:00 p.m. in the Sands Room. Guest speaker will be Burton Combes.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the association's Fifty Year Club, will honor the half-century-plus members at a special luncheon on Wednesday, April 30, at 12:30 p.m. Arthur A. Derrick of Durant, chairman of the board, will preside.

FLYING PHYSICIANS ASSOCIATION, MISSISSIPPI CHAPTER

The Mississippi Chapter of the Flying Physicians Association, Inc., will host a luncheon in the Caribbean Room, on Wednesday, April 30, beginning at 12:30 p.m. Thomas L. Kilgore of Jackson is president and Thomas R. Singley of Pascagoula is secretary-treasurer.

WEDNESDAY / Continued

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will have a luncheon on Wednesday, April 30, at 12:00 noon in the Stardust Room. Bruce E. Atkinson of Amory is president and W. Mack Gorton, Belzoni, is secretary-treasurer.

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

The Mississippi Association of Pathologists will meet for a luncheon in the Pacific Room on Wednesday, April 30, at 12:00 noon. Officers of the association are William B. Wilson, Jackson, president; Benella Oltremari, Greenville, president-elect; T. G. Puckett, Hattiesburg, secretary; David R. Steckler, Natchez, treasurer.

MSMA MEMBERSHIP AND AUXILIARY BANQUET

"Un Plaisir Gastronomique," an evening of excellent cuisine and entertainment for MSMA and MSMA Auxiliary members, their families and guests, will begin at 6:30 in the Versailles Room of the Royal D'Iberville Hotel. Special guest speaker will be ABC news commentator Howard K. Smith.

FILM SERIES

"Whatever Happened to the Human Race?" is the title of a film series which will be presented on Monday, Tuesday and Wednesday from 12:00 noon until 5:00 p.m., in Room 102. Written and narrated by Francis A. Schaeffer, noted theologian and philosopher, and C. Everett Koop, surgeon-in-chief at Philadelphia's Children's Hospital, the film explores such topics as abortion, infanticide, euthanasia, human dignity and the future of man. The film consists of five episodes of one hour each.

MISSISSIPPI STATE MEDICAL ASSOCIATION AUXILIARY

57th Annual Session

Biloxi Hilton

April 27-May 1, 1980



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MRS. BARNETT
President



MRS. ROBERTS
President-Elect

REGISTRATION INFORMATION

The registration desk and Hospitality Center for the 57th Annual Session of the MSMA Auxiliary will be located on the First Level Lobby near the Grand Ballroom. Hours of registration will be:

Sunday, April 27 — 9:00 a.m.-4:00 p.m.

Monday, April 28 — 9:00 a.m.-4:00 p.m.

Tuesday, April 30 — 8:30 a.m.-9:30 a.m.

Hospitality Center hours will be 10:00 a.m.-4:00 p.m. daily.

ACTIVITIES CALENDAR

Sunday, April 27

9:00 a.m.	Hospitality Center	First Level Lobby
5:00 p.m.	Registration	
	Boutique Booth	

Monday, April 28

8:00 a.m.	Finance Committee Meeting	Pacific
9:30	MSMA House of Delegates	Emerald
11:00	Preconvention Board Meeting	Stardust
12:00-5:00 p.m.	Film Series "Whatever Happened to the Human Race?"	Room 102
6:00 p.m.	Tulane Medical Alumni Reception	Sands
	Arkansas Alumni Reception	Caribbean
7:00	Ole Miss Medical Alumni Reception	Royal D'Iberville

Tuesday, April 29

8:00	Officers Orientation Breakfast	Caribbean
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9:30	General Session	Grand Casino
	Call to Order and Invocation	
	Welcome	
	Greetings — Dr. Gerald P. Gable, MSMA President	
	Introductions	
	Memorial	
	Roll Call	
	Minutes	
	Reports	
	Business and Awards	
	Appointment of Delegates to AMA Auxiliary Convention	
	Speakers	
	Mrs. Harry S. Dvorsky, 1st Vice President, AMA Auxiliary	
	Mrs. Raymond M. Yow, President, Southern Medical Auxiliary	
	President's Message	
	Election and Installation of Officers	
	Courtesy Resolutions	
	Adjournment	

12:30 p.m.	Luncheon and Fashion Show	Grand Casino
	Invocation	
	Introductions	
	Recognition of Past Presidents	
	Guests	
	Presentation of 1980 President	
	"First Ladies of Mississippi Historical Fashion Show"	

3:00	Postconvention Board Meeting	Atlantic
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Wednesday, April 30

7:30 a.m.-9:30 a.m.	"Coffee With Binny," Mrs. Clarence H. Webb, Jr. Physicians and spouses invited	Dunes
9:30	Gemologist from Smithsonian Lecture and Display Physicians and spouses invited	Dunes
12:00-5:00 p.m.	Film Series	Room 102
12:30	Past Presidents' Luncheon	Dunes
6:30	"Un Plaisir Gastronomique" An evening of excellent cuisine and entertainment. Special address by noted ABC news commentator Howard K. Smith	

BOUTIQUE BOOTH

A collection of hand-made articles and crafts will be offered for sale. The proceeds will go to the AMA-ERF, and credit will be issued for each auxiliary toward the AMA-ERF Award.

AUXILIARY / Continued

COMMITTEE CHAIRMEN

Convention Chairman
MRS. MARION H. BROWN
Brookhaven

Registration
MRS. ENRIQUE FLECHAS
Natchez

Hospitality Center
MRS. JOHN ESTESS
Hollandale

Luncheon
MRS. DAN KEEL
Brookhaven

Boutique Booth
MRS. ALVIN BRENT
Jackson

Publicity
MRS. STANLEY HARTNESS
Kosciusko

SPECIAL EVENTS

- “First Ladies of Mississippi Historical Fashion Show”
- “Coffee With Binny”
- Gemologist Lecture and Display
- “Whatever Happened to the Human Race?” new film series
- “Un Plaisir Gastronomique” featuring Howard K. Smith
- Boutique Booth

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Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

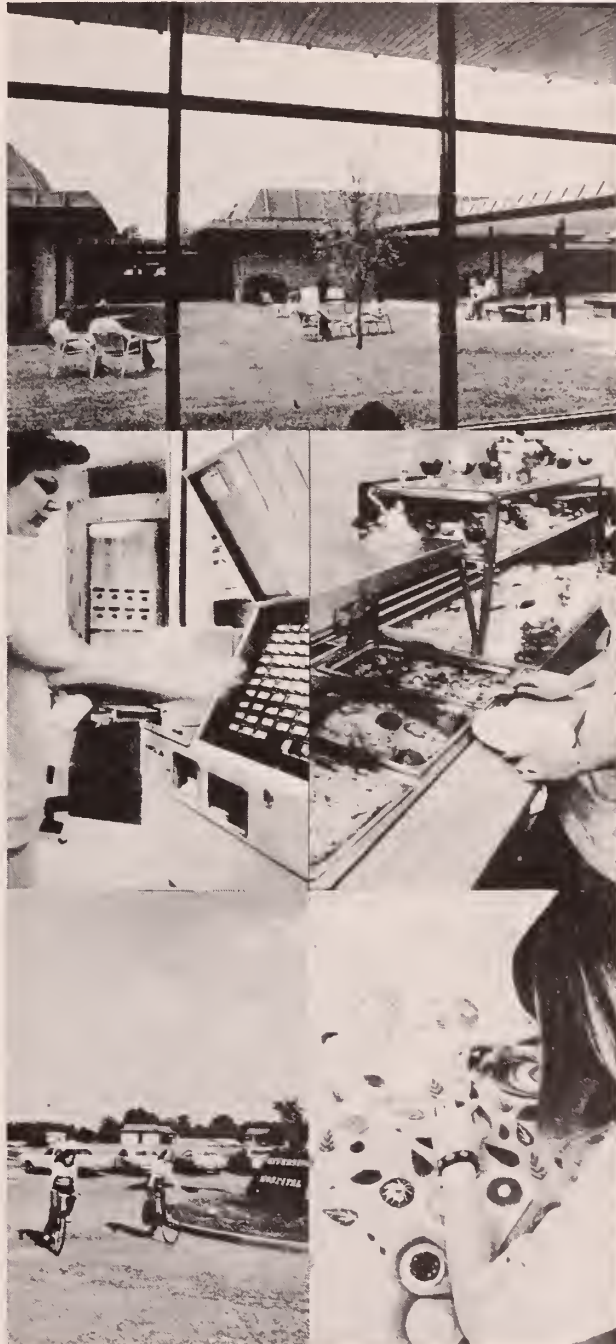
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.

Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030





The President Speaking

FTC Broadens Its Attack on Medicine

GERALD P. GABLE, M.D.
Hattiesburg, Mississippi

To what degree will the Federal Trade Commission (FTC) be able to encroach on our medical professionalism and the public-spirited responsibilities that go with it?

This question loomed when the FTC challenged the AMA's ethical ban on physician solicitation of patients. It also is looming again on the issue of the FTC and medical-school accreditation, an issue that had been in abeyance during a two-year grace period.

The advisory committee to the U. S. Commissioner of Education is scheduled to open a hearing April 21 on the FTC's petition to dislodge the Liaison Committee on Medical Education (LCME) as accrediting body for medical schools.

As cosponsor of the LCME — along with the Association of American Medical Colleges (AAMC) — the AMA is again the prime target of the FTC action, just as in the ongoing case on physician advertising and solicitation.

FTC lawyers exultantly smell a rat in the AMA's accreditation role. They contend the Association wants to limit the number of schools and graduates for the same basic reason it allegedly wants to limit the scope of advertising: to stifle intraprofessional competition.

The contention is out of touch with the facts, of course. Instead of being held down, the number of approved medical schools has surged (with full AMA support) from 85 in 1960 to 126 today. Enrollment in that time has more than doubled.

Well, the FTC counters, the LCME just might sometime restrict the school growth.

Another federal agency — HEW — foresees no restriction. In a recent report, HEW stated: "Our nation's schools are currently geared to produce doctors at a rate that should put the total number in balance with our national needs by the 1980s. By the 1990s, we should have a supply greater than we will need."

In its move on accreditation, the FTC is joined by such "public interest" groups as Common Cause and Sidney Wolfe's Public Citizen Health Research Group. But we feel it's clearly in the public interest that the AMA continues waging arduous if costly battles to keep medical professionalism intact. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 4

APRIL 1980

AMA-ERF Needs Your Support

Medical student loans, guaranteed by the AMA Education and Research Foundation, are important in themselves but also for a reason that goes beyond money. These loans demonstrate in clear terms that our AMA Federation is interested in nurturing tomorrow's physicians.

Since the program's inception in 1962, some 75,000 loans totaling over \$90 million, have been guaranteed.

Lately, however, the program's resources have been severely pinched; the demand for loans has been mounting, while educational expenses continue to escalate. To a great extent the demand has increased because federal and other sources of financial assistance for medical education have been drying up.

Last year there were sufficient funds for 2,000 students and physicians in training through the ERF Program. This compares to over 4,000 such loans the year before.

It would be a sad day if the program were to languish for lack of sufficient resources to meet the loan demand.

Just a little effort from medical families and from all the state and county societies would do much to proclaim their confidence in America's future health care.

Funds can be earmarked to the medical school of your choice. This is the best way to support your university and the student body.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

LETTERS

(Editor's Note: The following letter was written by AMA Executive Vice President James H. Sammons, M.D., to Senator Thad Cochran.)

Dear Senator Cochran:

On behalf of the medical profession throughout our country, I would like to commend you for your cosponsorship of, and your vote last week on, the McClure-Melcher amendment to the Federal Trade Commission authorization bill, S. 1991.

Although we were understandably disappointed that the proposal — which would have temporarily prohibited the FTC from further overriding of state laws while Congress evaluated the Agency's appropriate role with respect to certain professions — was not agreed-to, we were heartened by the narrowness of the margin as well as by the commitment from the Subcommittee Chairman to promptly address the issue. Moreover, the mere existence of the amendment seemed to be responsible for the FTC pullback on the Blue Shield plan board composition controversy.

We think the *Wall Street Journal* accurately assessed the McClure-Melcher outcome by reporting, "The relatively close 47-to-45 vote reflected the belief of many Senators that the FTC hasn't any business intervening in state regulation of professional groups." We also found very timely and significant the action of the U.S. Court of Appeals on the same day (Feb. 6) striking down the decision of the FTC in the ophthalmic goods case and remanding the rule back to it stating, "... the Commission's proposed pre-emption of state law is almost as thorough as human ingenuity could make it."

Since the questions of dual regulation and a federal agency's substituting its judgment for that of a state legislature will undoubtedly be before the United States Senate again, our Association is greatly encouraged by the posture you have taken in this instance. We are only one of many professions which share a concern over the FTC's expansionist policies in the non-commercial area, but as such we appreciate the kind of support and understanding which you have demonstrated.

With sincere best regards,
JAMES H. SAMMONS, M.D.

Doctor, Did You Mean What You Said?

Do you want your telephone to ring off the hook? Do you want more money in accounts receivable than you have in the bank? How about running at least two hours behind schedule every Monday?

Three phrases that are guaranteed to produce these nightmarish results are: "Just give me a call and let me know how you feel," "Don't worry about the bill," and "Come in and see me on Monday."

Chances are these three phrases are familiar to you — maybe you've even used them. But perhaps you didn't realize the kind of trouble these phrases can cause in your office. Let's take a look at the difference between what was meant, what was said, and what effect the comments listed above had on patients and your office.

One physician says that when he started practice, he'd close each exam by saying, "Just give me a call and let me know how you feel." And most patients did just that. "As my practice grew so did the number of patient callers. It got to the point where I was making nearly 25 callbacks a day, only to hear that the medicine or treatment regimen was working just fine." His nurse finally noticed the pattern and called it to his attention. The result is that needless callbacks have been reduced. Substitute phrases that he now uses to close an exam include: "If you still have pain in two days, call me," or "If you don't feel better in a week, call and make another appointment." In both examples, the patient instruction is more specific.

"Don't worry about the bill," is another phrase which causes problems. It usually works like this. You've just seen a patient. This patient looks up at you and says, "Ah, this treatment will probably mean a big bill and frankly . . ." before the patient can finish you ease toward the exam room door and say, "Don't worry about the bill — just get well."

You should realize that this is an instruction most patients will follow to the letter — in fact it may be the only instruction they follow. And it is this phrase that will ring in your ears as you look over your growing accounts receivable. If discussing money with patients makes you uneasy — and it shouldn't, by the way — have your staff help you. For instance,

instead of "Don't worry about the bill," why not say, "Please see the bookkeeper, she'll make arrangements for you," or something like that.

If you really don't want the patient to worry about paying you and you stand ready to forgive the amount due, be sure you communicate this to your staff.

Now let's look at the last phrase. A friend of mine tells me that whenever he wants a "squeeze-me-in" appointment with his physician, he calls him at home on Sunday. "Without fail," he smiles, "the doctor says for me to come in and see him on Monday." And, he points out that the doctor is a soft touch compared to the medical assistant in his office.

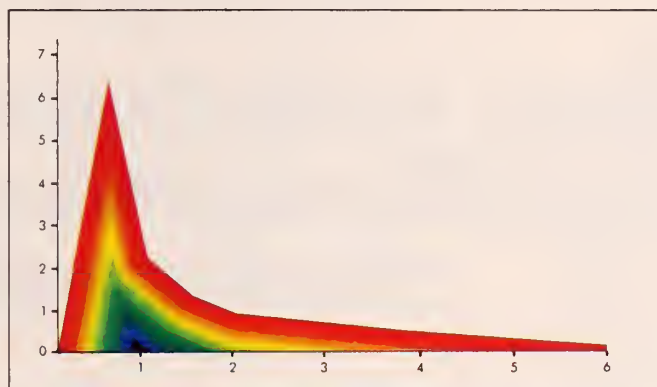
Watch out for patients like my friend. Many times patients like him truly aren't feeling well, and while they don't need an emergency room visit, a prescription, or a house call, they do want and/or need something from you. The key question to ask yourself is, "Do they need an appointment on Monday?" Oftentimes patients like my friend have simply neglected to follow the routine of calling to set aside some time for a visit for their non-urgent problem. And do consider the result . . . a crowd gathers on Monday morning in your exam room that is so large it rivals 5th Avenue on the day of the Easter parade.

The solution? Try what an established Illinois physician with a busy practice does. He tells patients, "Please be sure to call my office first thing on Monday and tell the medical assistant that I want to see you." And be sure that your office staff leaves a certain number of appointments open for these call-ins. It's a bit of preventive medicine that will cut waiting time for patients, keep you and your staff sane and on schedule, and accommodate the patient who does need to be seen.

Hopefully, these new ideas will result in improvements in your practice communications.

(Editor's Note: This month's column was condensed from an article by Karen Zupko, director of AMA's Department of Practice Management. Please address your practice management inquiries to Bucky Murphy, P. O. Box 5229, Jackson, MS 39216.)

more
than just spectrum



New **CYCLAPEN**[®]
(cyclacillin) Tablets/
Suspension

**Efficacy
proven in the
treatment of
otitis media,
bronchitis,
pneumonia and
upper respiratory
tract infections*
with fewer
side effects.**

*Due to susceptible organisms
(See important information on last page.)



New CYCLAPEN[®]

(cyclacillin) Tablets/
Suspension

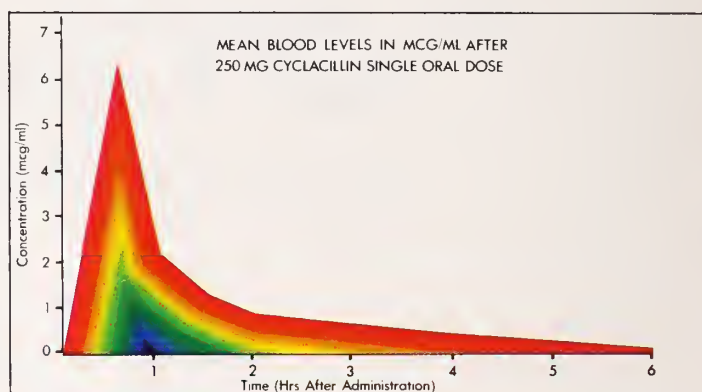
efficacy with fewer side ampicillin confirmed in studies of 2,581

Rapid, virtually complete
absorption from GI tract

Rapid onset of action—
mean peak serum levels
within 30 minutes

Exceptionally high peak
blood levels—3 times
greater than ampicillin
(clinical efficacy may not
always correlate with
blood levels)

Rapidly excreted
unchanged in the urine—
1½ times faster than
ampicillin



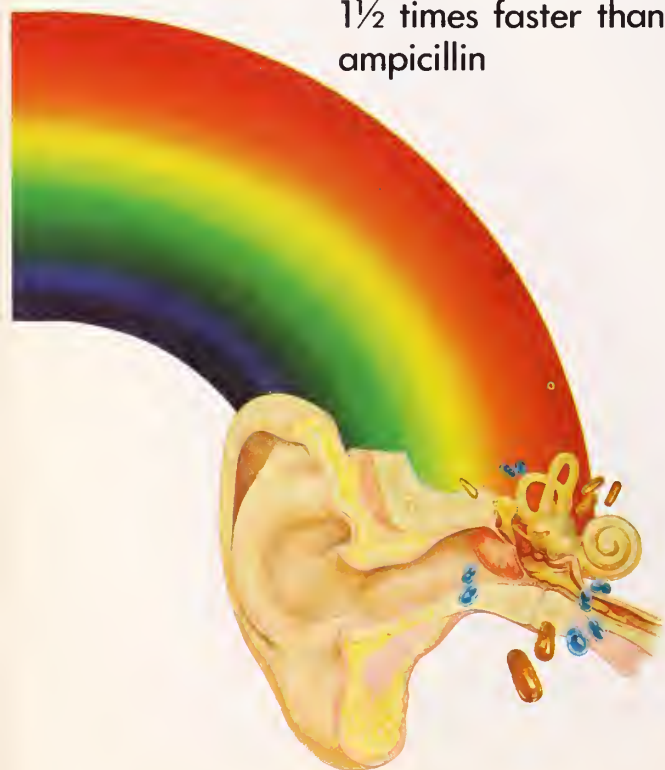
Clinical efficacy of CYCLAPEN[®] in otitis media[†]

Causative Organism			No. of Patients
<i>S. pneumoniae</i>	96		82
	95		
<i>H. influenzae</i>	88		96
	85		
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>			

more than just spectrum in otitis media

*Includes all patients treated. 2,415 evaluated for safety;
1,819 evaluated for efficacy.

[†]Due to susceptible organisms.



effects than double-blind patients*

Fewer side effects with CYCLAPEN® in
double-blind studies to date^{1,2}

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant ($P < 0.001$)	

CYCLAPEN® (cyclacillin)

Effective for otitis media[†] in children

- Excellent clinical results in eliminating the two most common causative organisms in otitis media
- Significantly lower incidence of diarrhea and skin rash in children treated with CYCLAPEN® Suspension

	diarrhea	rash
CYCLAPEN	9.1%	2.1%
ampicillin	19.2%	5.8%
	$P < 0.001$	$P < 0.03$

1. Gald JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cycloclillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.

2. Data on file, Wyeth Laboratories.

(See important information on next page.)



In bronchitis,
pneumonia and
upper respiratory
tract infections[†]

High cure rate with CYCLAPEN®		
Causative Organism	Branchitis/Pneumonia†	Na. of Patients
<i>S. pneumoniae</i>	100	73
	95	
Chronic Bronchitis† (acute exacerbation)		
<i>H. influenzae</i>	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to <i>H. influenzae</i>	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100	44
	86	
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>		

more than
just spectrum
CYCLAPEN®
(cyclacillin) Tablets/
Suspension

Wyeth Laboratories
Philadelphia, Pa 19101

New from Wyeth Laboratories

CYCLAPEN[®]
(cyclacillin) Tablets/
Suspension



more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN[®] Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied
CYCLAPEN[®] (cyclacillin)
tablets:
250 mg scored tablets
500 mg scored tablets

Indications

Cyclapen[®] (cyclacillin) has less *in vitro* activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen[®] is indicated for the treatment of the following infections.

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci. Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*).

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*.

Acute exacerbation of chronic bronchitis caused by *H. influenzae*.*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (Integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS. SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated

Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

CYCLAPEN[®] (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS.)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SCOT elevations have been reported.

Dosage and Administration
INFECTION* ADULTS

CHILDREN
Dosage should not result in a dose higher than that for adults.

Respiratory Tract Infections & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
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Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses

*As with antibiotic therapy generally treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure
Based on a dosage of 500 mg q.i.d. the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of <50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of >10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa 19101



MEDICAL ORGANIZATION

Physicians Urged to Report Pesticide Poisonings

The Mississippi Epidemiologic Studies Program requests the participation of physicians in the Pesticide Incident Monitoring System (PIMS), a nationwide effort to document pesticide poisonings of humans. The program also monitors incidents involving the exposure of animals and the environment to pesticides.

Physicians are urged to report any incidents of human exposure to pesticides. The ESP provides poison information forms which enable physicians to document pertinent information about the poisoning incident — time, place, pesticide involved, occupational relationship, route of exposure, major symptoms exhibited, and type of medical treatment administered. Identity of the patient is not required.

Information is requested on all pesticide related cases, including acute, subacute and chronic exposure. The ESP seeks information about cases encountered by physicians during 1979, as well as any future cases.

The ESP is located at the State Chemical Laboratory on the Mississippi State University campus. The program operates under contract with the Environmental Protection Agency and is responsible for implementing the monitoring system in four states — Alabama, Kentucky, Mississippi and Tennessee.

As a service to physicians, the Laboratory provides free cholinesterase determinations and pesticide residue analyses to aid in the diagnosis and confirmation of poison cases. As an added service, the Laboratory will provide each physician with a copy of Dr. Donald Morgan's *Recognition and Management of Pesticide Poisonings*.

For more information on the ESP in general and the PIMS in particular, write to Dr. Larry G. Lane, Mississippi Epidemiologic Studies Program, P.O. Box CR, Mississippi State, MS 39762 or call 325-4308.

Dr. Clark Will Direct ACS Trauma Symposium

Richard H. Clark, M.D., of Hattiesburg, is course director for the second annual Trauma Symposium,

sponsored jointly by the Committee on Trauma of the American College of Surgeons and the Region IV Committee on Trauma of the ACS. The event is scheduled for June 20-22, at the Dutch Inn, Lake Buena Vista, Disney World, FL.

Course curriculum will include such topics as: pediatric trauma, head injuries, renal failure, spinal injuries, management of the cardiovascular system, infection in trauma, chest injuries and blunt trauma.

The symposium has a limited registration of 300. Fee for the course is \$175 for physicians; \$75 for nurses and residents.

Advance registration forms may be obtained by writing to Dr. Clark at 415 S. 28th Avenue, Hattiesburg, MS 39401; or the Trauma Department, American College of Surgeons, 55 E. Erie St., Chicago, IL 60611.

MMFES Schedules Annual Meeting

"Avoiding Malpractice Lawsuits" is the topic for discussion at the annual membership meeting of the Mississippi Medical Fraternal and Educational Society (MMFES) at the Biloxi Hilton on Sunday, April 27. Walter W. Epps, Jr., J.D. will be the guest speaker.

Mr. Epps is a native of Meridian, Mississippi. He has 28 years of legal experience in the Mississippi forum of justice. He is generally acknowledged as one of the state's leading insurance defense counsels specializing in personal injury litigation.

The MMFES meeting, held in conjunction with MSMA's 112th Annual Session, is slated to begin at 3:30 p.m. in the Emerald Room.

112th Annual Session of MSMA

April 27-May 1, 1980
Biloxi Hilton

Mark Your Calendars Now!

PERSONALS

JOHN J. COOK announces the opening of his office for the practice of general surgery at 224 North Bierdeman Road in Pearl.

W. MEL FLOWERS of UMC, president-elect of the Southeastern Chapter of the Society of Nuclear Medicine, attended the society's February meeting in Nashville.

MARTIN B. HARTHCOCK, JR., of Jackson, announces the relocation of his office for the practice of plastic surgery to Suite 210, Hinds Professional Building.

HARPER HELLEMS of UMC was a program participant for a recent course on clinical cardiology and hypertension in Biloxi.

LUCIEN HODGES of Jackson was elevated to the presidency of the Southern Neurosurgical Society at the society's March meeting at Hilton Head, NC.

JAMES HUGHES of UMC taught a continuing education course in Toronto, Canada, in February.

HERBERT LANGFORD of UMC attended the Food and Drug Administration's cardiorenal advisory committee meeting in Washington, DC, in February.

SAMUEL JOHNSON of UMC recently participated in a site visit to the Florida Rehabilitation Center in Daytona Beach.

DOUGLAS LANIER, JR., has affiliated with EDMUND H. CRANE of 1308 44th Avenue in Gulfport for the practice of internal medicine and nephrology.

FRANK T. LANSDEN of Biloxi was recently elected chief of staff of Gulf Coast Community Hospital.

THOMAS R. MCFARLAND of 304 11th Avenue in Lumberton announces the association of DANIEL J. STEPP for the practice of family medicine and obstetrics.

FRANK G. GRUICH of Biloxi has been recertified as a diplomate of the American Board of Obstetrics and Gynecology.

ROBERT R. SMITH of UMC presented a paper at the Fifth International Joint Conference on Stroke and Cerebral Circulation at Lake Buena Vista, FL, in February.

Pulmonary Consultants, P.A. (BARRY L. WHITES, M. D. HARDY, JR., and GUY D. CAMPBELL) announce their office relocation to 2660 Crane Ridge Drive, Suite A, in Jackson.

NEW MEMBERS

BATTLE, WILLIAM ROBERT, Jackson. Born Jackson, MS, Sept. 22, 1952; M.D., University of Mississippi School of Medicine 1976; interned University Medical Center, Jackson, MS, one year; anesthesiology residency, University of Texas, Galveston, 1977-79; elected by Central Medical Society.

DEFORE, WOODROW WILSON, JR., Jackson. Born Jackson, MS, Nov. 11, 1947; M.D., University of Mississippi School of Medicine, 1972; interned Baylor College of Medicine, Houston, TX, one year; surgery residency, same, 1973-77; thoracic surgery residency, Emory University, Atlanta, GA, 1977-79; elected by Central Medical Society.

FRIEDMAN, CHARLES ALVIN, Jackson. Born New York, NY, Aug. 26, 1945; M.D., Johns Hopkins University School of Medicine, Baltimore, MD, 1971; interned, same, one year; pediatric residency, National Institute of Health, Bethesda, MD, 1973-74; pediatric residency, Childrens Hospital, Boston, MA, 1974-76; neonatology fellowship, Duke University, Durham, NC, 1976-78; elected by Central Medical Society.

GLEAVES, JAMES R., Meridian. Born Buffalo, NY, June 30, 1944; M.D., University of Alabama School of Medicine, Birmingham, AL, 1970; interned Lloyd Noland Hospital, Fairfield, AL, one year; surgery residency, same, 1971-75; elected by East Mississippi Medical Society.

HOLLADAY, WALTER ROBERT, Meridian. Born Meridian, MS, June 17, 1923; M.D., Northwestern University Medical School, Chicago, 1947; interned Cook County Hospital, Chicago, one year; rotating general residency, Dade County Hospital, Miami, FL, 1948-50; elected by East Mississippi Medical Society.

JONES, DANIEL W., Laurel. Born Morton, MS, Mar. 19, 1949; M.D., University of Mississippi School of Medicine, 1975; interned University Medical Center, Jackson, MS, one year; internal medicine residency, same, 1976-78; elected by South Mississippi Medical Society.

MCMAHAN, LYNN B., Hattiesburg. Born Mansfield, OH, Nov. 4, 1946; M.D., University of Mississippi School of Medicine, 1972; interned Methodist Hospital, Dallas, TX, one year; ophthalmology residency, University of Alabama, Eye

Foundation Hospital, Birmingham, 1973-76; elected by South Mississippi Medical Society.

NELSON, JOHN C., Hattiesburg. Born Hattiesburg, MS, Aug. 14, 1953; M.D., University of Mississippi School of Medicine, 1977; interned University of South Alabama, Mobile, one year; elected by South Mississippi Medical Society.

O'NEAL, KELLY R., JR., Hattiesburg. Born Charlotte, NC, Nov. 11, 1947; M.D., University of Mississippi School of Medicine, 1972; interned St. Elizabeth Medical Center, Dayton, OH, one year; ob-gyn residency, Emory University, Grady Memorial Hospital, Atlanta, GA, 1975-78; elected by South Mississippi Medical Society.

PEACOCKE, IVAN L., Jackson. Born St. Louis, MO, Aug. 1, 1932; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1958; interned North Carolina Baptist Hospital, Winston-Salem, one year; pathology residency, Vanderbilt University, Nashville, 1959-60; pathology residency, Duke University, Durham, NC, 1962-66; elected by Central Medical Society.

SANDERS, JOHN R., Tupelo. Born Greenwood, MS, Oct. 8, 1946; M.D., University of Mississippi School of Medicine, 1971; interned University Medical Center, Jackson, MS and St. Paul Hospital, Dallas, TX, one year; ob-gyn residency, University Medical Center, Jackson, 1974-76; elected by Northeast Mississippi Medical Society.

POSTGRADUATE CALENDAR

April 10-12, 1980

LIVER DISEASE UPDATE

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine Division of Digestive Diseases, the American College of Gastroenterology and the Medical Center Division of Continuing Health Professional Education.

Coordinator: James L. Achord, M.D., professor of medicine and director, Division of Digestive Diseases, University of Mississippi School of Medicine.

The program will review new concepts in hepatology and their clinical applications. Medical and, where appropriate, surgical aspects of

liver disease will be discussed. Fee: \$150. Credit: 14.5 contact hours (1.45 CEU) Category I of the Physician's Recognition Award, AMA: AAFP credit applied for.

April 25-26, 1980

ADVANCED CARDIAC LIFE SUPPORT PROVIDERS
COURSE

Forrest County General Hospital, Hattiesburg

Sponsored by the University of Mississippi School of Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Thomas J. Herrin, M.D., associate professor of anesthesiology, University of Mississippi School of Medicine.

This course is open to physicians and other health professionals who are certified by the American Heart Association in basic life support and who are actively engaged in advanced cardiac life support on a daily basis. Fee: \$100. Credit: 12 contact hours, (1.2 CEU) Category I of the Physician's Recognition Award, AMA.

FUTURE CALENDAR

May 3-4, 1980

CARDIOVASCULAR NUCLEAR MEDICINE
University Medical Center, Jackson

May 6-10, 1980

HAND SURGERY
Ocean Springs, Mississippi

July 16-17, 1980

NEWBORN METABOLISM
University Medical Center, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

Medico-Legal Brief

Court Tells Parents No Laetrile

A trial court properly continued in effect a prior court order requiring that a young leukemia patient undergo chemotherapy and ordering his parents to cease metabolic therapy, the highest court of Massachusetts ruled.

The boy, born in December 1975, was suffering from acute lymphocytic leukemia. By September

30, 1977, the disease was in a state of remission. Thereafter, the parents, without the knowledge of the attending physician, discontinued the child's medication. By February 1978, the disease had recurred. When the parents declined to resume the treatments, the physician resorted to the courts. A trial court found the child to be in need of care and protection and ordered the parents to have the child undergo chemotherapy under the supervision of any board-certified hematologist of the parents' choosing. The court also vested custody of the child in the Department of Public Welfare. The high court affirmed that order.

The parents then asked the trial court for a review and redetermination of the current needs of their child. At the hearing the parents sought legal authority to supplement chemotherapy with a program of

metabolic therapy involving administration of enzymes, large doses of vitamins, and laetrile. The court continued its earlier order, and the parents appealed.

Affirming the decision, the Massachusetts Supreme Judicial Court noted that the parents had taken their child to Mexico for treatment. The evidence supported the finding that the metabolic treatment posed serious risks of harm to the child. The metabolic treatment was not only medically ineffective but was poisoning the child and was not consistent with good medical practice, the court said. The treatment was contrary to the best interests of the child and continued custody in the Department was necessary for proper medical treatment, the court added. — *Custody of a Minor*, 393 N.E.2d 836 (Mass. Sup. Jud. Ct., Aug. 9, 1979)

Editor's Note: The three-year-old boy, Chad Green, later died in a laetrile clinic in Tijuana, Mexico.

RNs, ARE YOU READY FOR A NEW LIFE?

The Navy Nurse Corps is where it's happening. We've expanded the age limits to give nurses between the ages of 20 and 40 the opportunity to discover the professionalism of the naval service's Nurse Corps. A variety of programs are available at a starting salary of \$12,700 to \$17,600, with 30 days paid vacation, choice of work location, free medical and dental care and opportunities for advanced education. A BSN, MSN or diploma with 12 months experience is required. For more information, call (901) 521-3124 (in Memphis) or toll free 1-800-532-6665 in Tennessee. Outside Tennessee call 1-800-238-5580. Ask for the nurse representative.

ANUSOL-HC®

SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

IT WAS
NUMBER ONE
IN 1959

AND IT STILL IS...

The professional source of
modern anorectal comfort

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

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Full information is available on request.

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RECOLLECTIONS

Six scientific sections scheduled formal sessions during MSMA's 92nd Annual Session in Jackson, according to the April 1960 JOURNAL MSMA. Lecture topics and speakers included: "Congenital Anomalies of the GU Tract," by Joel L. Alvis, M.D., of Jackson; "Surgical Resection for Tuberculosis in Children," by Jesse L. Wofford, M.D., of Jackson; "Diagnosis of Headaches by Therapeutic Tests," by C. Hal Cleveland, M.D., of Gulfport; "Oophorectomy in Carcinoma of the Breast" by Dr. William L. Thornton of Meridian; "Indications and Technique for Intra-Arterial Transfusions in Gynecology" by J. Hurd Gaddy, M.D., of Gulfport; and "Complications of Diverticulitis of the Colon" by Drs. Jack V. King and Dewitt T. Brock of Jackson.

Annual Session general chairman was Dr. W. E. Lotterhos of Jackson. Scientific exhibits included "Unusual Causes of Intestinal Obstruction" by Dr. William O. Barnett of Jackson; "Nerve Injuries of the Hand" by Dr. J. T. Davis of Corinth and "Lung

Pathology in Plastic" by Drs. J. L. Wofford and H. K. Strauss of Jackson.

Papers published in JOURNAL MSMA in April 1960 included: "Techniques and Complications of Spinal Anesthesia" by Drs. L. W. Fabian, M. A. Carnes and D. P. Smith of Jackson; and "Political Action by Physicians" by Dr. C. G. Sutherland of Jackson.

News stories recounted a hospital building boom in Jackson with construction projects underway at Baptist, St. Dominic's, VA and University hospitals. When completed, the article continued, some 1,500 beds would be provided in the city's four hospitals.

PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

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ASSOCIATES or physicians interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

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PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

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POSITIONS AVAILABLE IMMEDIATELY. The Jackson VA Medical Center is hiring physicians to work in the Admission Office. Primary care specialties (internal medicine, family practice, general practice, emergency medicine) will be given priority. Valid medical license in any state required. Regular hours, competitive salary, and liberal fringe benefits make this a particularly attractive position. Address inquiries to: William A. Causey, M.D., Chief, Medical Service, VA Medical Center, Jackson, MS 39216. Telephone (601) 362-4471, ext. 1841.

Index to Advertisers

Alpha Therapeutics	14
American Medical Association	14D
Boeringer Ingelheim	10B, 10C, 10D
Burroughs Wellcome	14A
Canton Exchange Bank	14
Citizens Bank	82
Fenwick Hall	4
Harreld Chevrolet	82
Janssen Pharmaceuticals	6, 7
Eli Lilly and Company	18
Miss. Medical Fraternal and Educational Society	12

Parke, Davis	91
Premier Printing	92
Pharmacia Laboratories	17
Riverside Hospital	83
Roche Laboratories second, third and fourth covers, 3	
William H. Rorer, Inc. 14B, 14C, 14D	
Smith, Kline & French	10A
Southern Environmental Products	8
U. S. Air Force	69
U. S. Navy	90
Wyeth Laboratories	86A, B, C, D
Thomas Yates	15

IN CONCLUSION

Physicians can expect an epidemic of smoking related disease among women and can anticipate that lung cancer deaths will exceed breast cancer deaths in women within three years, Surgeon General Julius B. Richmond recently predicted. His report stated that over the next few years, women smokers' risk of lung cancer death will approach 8-12 times that of nonsmoking women, the same relative risk as men. An increase in oral and laryngeal cancer can also be expected, due to the synergistic reaction of excessive alcohol ingestion with cigarette smoking.

Approximately 15% of U.S. businesses have begun programs to encourage and help their employees quit smoking, and many more are considering them. Many have policies restricting or prohibiting smoking in the workplace. Smoking programs ranked third among company-sponsored health education programs, after high blood pressure and diet/weight control programs. For the most part, companies undertaking "stop smoking" programs are doing so with existing staff and monetary resources, with help from volunteer agencies.

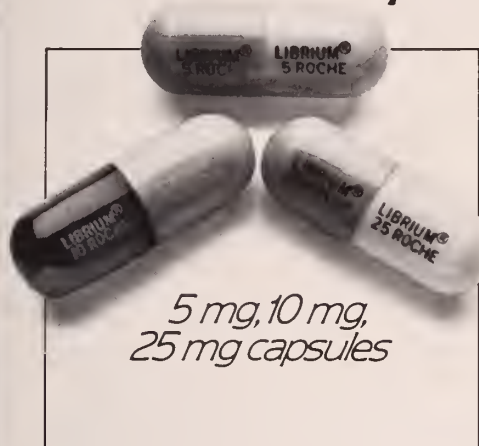
Some 100 million Americans are afflicted with chronic illnesses, accounting for half of the visits to physicians' offices annually. The Robert Wood Johnson Foundation has awarded grants totaling \$4.4 million to eight hospitals to establish projects to offer better, long-term care for ambulatory patients suffering from such chronic illnesses as high blood pressure, stroke, arthritis, diabetes, some lung diseases and some cancers. The projects will be staffed by specially trained nurses working under the supervision of physicians.

The Alan Guttmacher Institute has called upon physicians to take advantage of their unique opportunities for counseling adolescents about sexuality and says acting as educator is not necessarily time consuming if incorporated into the physical exam. Noting that sex education is "woefully inadequate," the Institute reminds that some 1 million teens age 15-19 (and 30,000 under age 15) become pregnant each year. Of the 600,000 teens who have their babies, one-quarter become pregnant again within one year. Most are on welfare, at a cost to the public of \$8.3 billion.

Americans are fitter than ever but are "obsessed with their health," said Dr. Lewis Thomas of Memorial Sloan-Kettering Cancer Center in "U.S. News & World Report." He credited effective antibiotics for making disease "unacceptable" today, while in an earlier time it was considered a natural fact of life. He said "coping with diseases that we really do not yet understand" contributes to high costs. He criticized medical student selection criteria (which emphasize science skills) for overlooking those who would have "character" befitting a profession which is also an art.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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with relief of anxiety*

Please see preceding page for a summary of product information.

May 1980

BALCONY

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Contents:

Shoulder Arthrography

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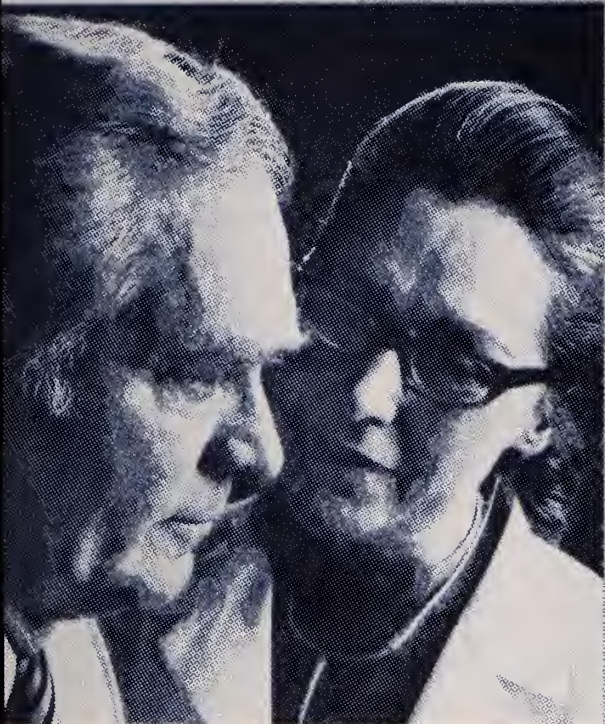




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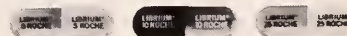




The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

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chlordiazepoxide HCl/Roche



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of anxiety***

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- ☐ Minimal effect on mental acuity, in proper dosage
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Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Bipartisan Congressional Group Offers Budget Cuts

For the past five months, about 60 Congressmen — both Republicans and Democrats — have been critically examining federal spending, and looking for ways to reduce it. Recently Philip Gramm (D-Tex) and Dave Stockman (R-Mich) held a press conference to announce the group's recommendations in a report, the "Emergency Fiscal Year 1981 Budget Reduction Plan of the Bipartisan Coalition for Fiscal Responsibility."

This 53-page study contains some of the most sweeping budget cuts — \$26 billion worth — and most scathing criticism of government programs seen recently.

"Given the amount of time that Congress has to put the nation's fiscal house in order, it is simply impossible to expect that the major legislative changes required to truly redirect agency incentives could be enacted in time to affect the level of regulatory activity to be undertaken in FY 1981. We can, however, impose a curb on the direct outlays of the regulatory agencies through the budget process, forcing the agencies to concentrate on only those activities that are of the highest priority and provide the greatest social payoffs. To that end, we propose an across the board reduction in regulatory agency budgets. The benefits to be gained by these reductions — in the form of greater freedom for our economy to work its way out of the present mess — will far outweigh the on-line budget savings realized from these reductions."

"We want to put actual programs on the operating table," Stockman told reporters. The report does. It blasts the Center for Disease Control's \$3 million "risk reduction" programs, "which turn out to be largely sex education efforts"; the "prevention formula grant program, which will undoubtedly pass along to the local planners and grantsmen the task of deciding which diseases to prevent"; the \$10 million fluoridation request; the "myriad 'prevention' programs to which members of Congressional authorizing subcommittees are wont to succumb. . . . We are convinced that these four programs alone provide sufficient justification for a sweeping retrenchment in prevention activities, and accordingly recommend a \$25 million reduction in outlays for prevention programs."

The Congressmen thought even less of the Health Planning Program's Health Systems Agencies and their Certificate of Need programs. "Recent authoritative studies," they charge, "demonstrate that the

(Continued on page 6)

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CONTENTS

ORIGINAL PAPER

- Radiologic Seminar CCII: 93 PATRICIA WEATHERSBY, M.D.
Shoulder Arthrography Jackson, MS

SPECIAL ARTICLES

- Maternal and Child 95 ALTON B. COBB, M.D.
Health in Mississippi Jackson, MS
- The HMO Program: 99 Compiled from AMA Reports
An Overview

EDITORIALS

- Dangerous Vehicles 103 MYRON W. LOCKEY, M.D.
Jackson, MS
- L'envoi 103 ARTHUR A. DERRICK, M.D.
Durant, MS

THIS MONTH

- The President Speaking 102 All Good Things Must Come
To An End
- Practice Management 105 The Doctor as Personnel
Mailbox Director
- Medical Organization 107 Coptiah Jail Seeks
Medical Accreditation
- Recollections 114 From the May 1960 Issue of
JOURNAL MSMA

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BIPARTISAN COMMITTEE/Continued

HSAs have merely shifted — and not reduced — investment in health care facilities. We believe that the whole health planning and CON process has been an unqualified failure, and must soon be replaced by a competitive market approach to controlling facilities and equipment investment levels and utilization patterns. Pending this major national health policy change, we believe that it would be prudent to start dismantling the vast health planning bureaucracy, and therefore recommend an 18% cut in FY 1981 outlays.”

By capping such Medicaid benefits as drug reimbursement, the group hopes to save another \$60 million. “Under Medicaid . . . states are given virtual carte blanche on eligibility definitions and benefit coverages within their programs — and a blank check on the Federal Treasury to finance at least half the cost. While Medicaid participation requires only a basic list of major health care services, many states have expanded on this list considerably, extending coverage for such high frequency costs as routine office visits, dental care, eyeglasses, drugs, and mental health services. If we are to avoid a doubling of program costs every three to four years, we must impose some sort of restraint on total state draw-downs on the Treasury in this fashion.”

The Congressmen would thus recommend an authorization ceiling, “similar to that currently in place on Food Stamps,” to be applied to the federal share of Medicaid program cuts, beginning in FY 1981 at a level equal to 105% of FY 1980 federal Medicaid outlays.

HEW Studies Health Costs

The Department of Health, Education and Welfare has announced a national study of the use, costs and financing of health care services in the U.S.

A joint project of the National Center for Health Statistics and the Health Care Financing Administration, the study will involve 10,000 households across the country. It will produce detailed information on the amounts and types of health care received during 1980, the costs of the services and the sources which helped to pay the bills.

The information will be used to measure and monitor the effects of existing health care financing programs on health status and costs.

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- scored tablet for dosage flexibility

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CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with narrow angle glaucoma; stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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SWW-417 I

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FIRST
for relief of allergy symptoms
Rx only

Please see adjacent brief summary of prescribing information.
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An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefaclor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [0703798]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

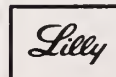
Note: Cefclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
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4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D. C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.



000482

NEWSLETTER

May 1980

Dear Doctor:

Public support of a national health insurance plan that would entail a tax increase dropped from 80% in 1978 to 72% in 1979, according to a survey by the Health Insurance Institute. But there has been an increase in the number of Americans who feel that health care costs are rising faster than other costs. Some 90% believe this is true, compared to 74% in 1974. A majority of respondents favor preventive health care and more outpatient surgery and tests as methods to lower costs.

Opponents of NHI tended to be college-educated residents of small metropolitan and rural areas. Reasons for opposition included: it would raise taxes, be wasteful and inefficient, lead to poor quality health care, and the belief that people should provide for themselves. There was also a feeling that there is too much government intervention in health care already.

Many Americans doubt the efforts of public and private institutions to control health care costs. Some 80% felt that doctors and hospitals are doing very little to control rising costs. Only 7% of the public feels that a national health insurance plan would be less expensive in the long term than current health care systems, however. The poll revealed a general pessimism that anything will be effective in lowering costs.

Medical Economics points out that the expert consensus is that NHI will not likely become a reality until the late 1980s. At that time, health care costs will have continued to rise so rapidly that a national plan will become a certainty, with built-in regulations for cost containment including a national fee schedule. One health planner sees NHI as a "means to rectify economic mistakes," such as Medicaid.

Government's biggest cost-control pressure is likely to be the HMO movement. Says Medical Economics: "Economically, the view in Washington is that prepaid care can do no wrong. While allocations were slashed for almost every health program for fiscal 1980, money for the HMO push will nearly double." Elsewhere in this issue is a summary of the HMO program.

It becomes official this month. The Department of Health, Education and Welfare ceases to exist on May 7. In its place is the new Department of Health and Human Services, which will continue to administer most of HEW's programs. Federal education programs will now come under the jurisdiction of the new Department of Education, created by Congressional action last year.

Sincerely,



Patsy Silver
Managing Editor



Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68%*	93%**
Mintezol ¹	35%†	45%††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX[®].

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done.

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JPI-023



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermax[®] TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions **PREGNANCY:** VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

Applications Decrease, Total Enrollment Peaks

The American Medical Association's 79th annual report on medical education noted a significant nationwide downturn in the number of applicants to medical schools. The University of Mississippi School of Medicine reports no appreciable change in the number of applicants. There continue to be around 375 applicants for the 150 available places in the freshman class, said a University spokesman.

The AMA report noted that the 1978-79 applicant total was 36,636 — a drop of almost 4,000 from the previous year. The peak year for medical school applications was 1974-75, with 42,624 applications.

Total enrollment in the 125 U.S. medical schools in 1978-79 was 62,754, an increase of 2,804 over the previous year. Total enrollment at University of Mississippi School of Medicine for the same year was 607. Current registration figures for the fall quarter showed 600 enrolled.

The nation's medical schools graduated a record number of new physicians at the close of the 1978-79 year — 14,966. This was an increase of four percent over the previous year. University of Mississippi graduated 145 last year, and expects to graduate 152 new physicians in June.

The AMA report also noted that the total number of women enrolled in medical schools increased by 920 over the previous year, and that ethnic minorities now number 7,768, or 12.5 percent.

C. H. William Ruhe, M.D., senior vice president for scientific affairs, remarked that the trend at the federal and state level "is in the direction of increasing regulation of the medical education system, increasing dictation of the terms of medical education and the content of the curriculum, and increasing regulation of the nature and location of physicians' practices."

He observed, also, that the movement of legislative support for medical education is waning, due to the general feeling in Congress that the supply of physicians is adequate and that financial support for medical schools can be reduced with safety.

Dr. Ruhe noted that in two states, there were efforts to restrict licensure of new physicians, and in other states there were proposals to limit the numbers of new residency programs. He commented that some states fear an over-supply of doctors or a relative imbalance between primary care physicians and secondary/tertiary care physicians.

**Next Month in Journal MSMA
"Perinatal Regionalization:
A Statement of Need"**

ANUSOL-HC[®]

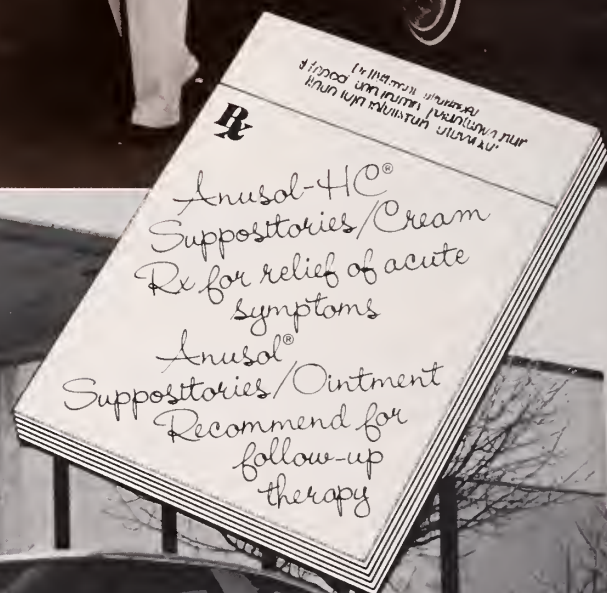
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IN 1959

AND IT STILL IS...

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modern anorectal comfort



ANUSOL-HC[®] SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC[®] CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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DATELINE

UM Preceptorship Program Featured Jackson, MS - University of Mississippi preceptorship program was among several featured in the April Issue of the American Academy of Family Practice publication, Reporter. Experiences of both students and physician sponsors were described. The difference in UM's program and that of other schools is the effort to match students with locations they are likely to return to, in the hope of helping reduce physician shortages in rural areas.

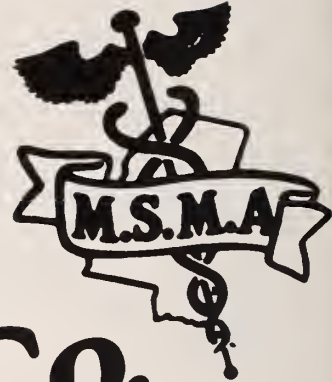
JAMA Adds Editions In French, Japanese Chicago, IL - In January JAMA published the first editions in French and Japanese, with circulation in France and Japan totalling 75,000. Spanish and Portuguese editions have a combined circulation of 160,000. Total circulations of foreign language editions of JAMA now totals over 2.5 million copies. Annual circulation of all AMA periodicals approaches 34 million copies, making AMA the world's largest medical publisher.

MD Liability To Third Parties Jackson, MS - Physicians may be held liable to persons other than their patients when third parties contract an infectious disease due to physician negligence, points out Dr. Durward Blakey of the Bureau of Disease Control. Usually the negligence involves failure to warn an infectious patient's family or failure to notify local health authorities of reportable diseases. But a recent California case involved the matter of confidentiality. A psychotherapist failed to warn an intended murder victim.

Pamphlets Available For Diabetic Athletes Chicago, IL - The AMA Council on Scientific Affairs has prepared a pamphlet for diabetic patients who wish to participate in sports. The pamphlet was prepared in response to many queries for information from insulin-dependent young people, their parents and coaches. Physiological information is included, as well as a table of caloric equivalents of exercise, to help plan food intake. Physicians may order copies from AMA's Order Dept., P. O. Box 82, Monroe, WI 53566.

Inflation Increases Value of Body Champaign, IL - An anatomy professor at the University of Illinois reports that double-digit inflation has driven up the value of the human body by 643% in the last 10 years. The body's minerals and trace elements, worth only 98 cents in 1970, now are worth \$7.28. But the average 150-pound body is worth less than a nickle a pound. The average person contains about 5 pounds of calcium. Oxygen accounts for 65% of body weight, carbon dioxide 18%, hydrogen 10% and nitrogen 3%.

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1970s
1980s
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Injection, 300 mg./2 ml.,
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Perdiem™ empties the bowel gently... by filling it.

Perdiem™ . . . the re-educative laxative
. . . relieves constipation by a unique combination of
physiological bulk stimulus and gentle pharmacologic
encouragement of peristaltic response.



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the Bowels



Constipation



Chronic
Constipation



Habituation to
Laxatives



Abuse of
Laxatives



Made in West Germany
(Please see next page for prescribing information)

Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives. A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently—up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules, 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.



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AMA Publishes Volume On Physician Distribution

There is one physician for every 535 persons in the United States.

Of the nation's 375,811 active physicians, 91.2% are engaged in direct patient care, bringing the ratio of physicians, excluding those who are employed by the U.S. government, to 187 physicians per 100,000 persons.

Washington DC ranks first among cities in the number of physicians, with 524 per 100,000 population. South Dakota ranks last among the states with 106 physicians per 100,000 people.

These facts are contained in the recently released American Medical Association's 16th edition of *Physician Distribution and Medical Licensure in the U.S., 1978*.

The 388-page volume, prepared by the AMA's Center for Health Services Research and Development, is comprised of statistical information from the AMA Physician Masterfile, the most comprehensive and complete source of physician data in the U.S.

The volume answers such diverse types of questions as how many of the total medical doctor population of 437,486 practice aerospace medicine; how many of the 45,540 women physicians are engaged in surgical specialties; how many doctors practice forensic pathology; and how many doctors live in Montana.

The work also contains data covering licenses issued to physicians by licensing boards, policies of state boards of medical examiners for initial licensure for graduates of U.S. medical schools, trends in the distribution of physicians, concentration of specialties and information on hospitals, population and income.

Information covering the ratio of physicians, excluding those in government (federal), in the U.S. reveals that New England has the highest ratio (238) and the lowest (134) is in the South Central division (Alabama, Kentucky, Tennessee and Mississippi).

The latest U.S. physician ratio to population of 187 per 100,000 is approximately 23% more than the 1971 figure of 152 physicians per 100,000 population.

While 1978 figures are not available to compare the U.S. ratio to European countries, information supplied by the World Health Organization shows that for 1975, the ratio in France is one physician for every 650 persons; in Italy the ratio is 1/490; in West Germany it is 1/500; in Sweden it is 1/580; and in Great Britain it is 1/760 persons.

In the area of physician manpower, the section describes the distribution of 375,811 physicians who are professionally active in the U.S. and possessions. The majority of active physicians, 342,714 or 91.2%, are classified in "patient care." Of the physicians engaged in "patient care," 54,893 are in general practice which includes family practice, 96,940 are in medical specialties, 98,567 are involved in surgical specialties and another 92,314 in "other specialties."

Of the 45,540 women physicians, approximately 6,688 more than in 1976, 11,979 are engaged in medical specialties and another 12,251 are involved in "other specialties."

Of the 56,197 physicians engaged in general practice, 21,611 are engaged full time in family practice medicine.

Included in the "other specialties" category are 584 physicians practicing aerospace medicine, another 234 physicians engaged in forensic medicine and another 756 practicing general preventive medicine.

The volume in addition includes data on the 20,242 physicians who work for the federal government. Most of the number, 41.3%, are located in the southern region and particularly in the South Atlantic Census Division. A total of 12.6% of the federal physician population is engaged in "administration," while 9.4% is involved in "research."

AMA Film Available To Medical Groups

A brand new, fast moving, colorful description of the myriad activities of the American Medical Association is available on loan, free to medical organizations in 16mm film and 3/4" videotape cassette.

This program provides in 11 minutes a review of the AMA, what it is, how it works, and what it does. A suggested brief introductory and concluding statement for use in presenting the film is provided along with copies of a brochure which capsulizes the presentation.

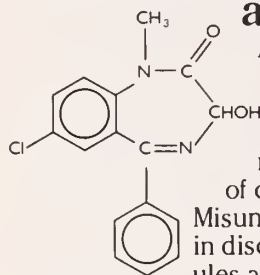
The presentation is ideally suited for meetings of medical societies, hospital staffs, your auxiliary, student and resident groups, or as an orientation for new members.

To reserve a copy, contact the Office of Medical Society Relations, AMA, 535 N. Dearborn St., Chicago, IL 60610. Be sure to specify how many companion brochures you may need and specify the date needed.

Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche)

Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.*

Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy.

Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they

learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms.

Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed as a *temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.



* Boyd JR, et al: *Am J Hosp Pharm* 31: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders,

possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

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barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances; stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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ORIGINAL PAPERS

Radiologic Seminar CII: Shoulder Arthrography

PATRICIA WEATHERSBY, M.D.
Jackson, Mississippi

MOST CLINICIANS are well aware of the advantages of knee arthrography, but recent reports indicate a growing interest in shoulder arthrography. As a result of their increasing activity in sports, such as tennis, racket ball, and other vigorous activities, people are suffering more shoulder injuries. In the more complicated types of injury, additional studies beyond physical examination and routine x-ray may be required. We have found that the shoulder arthrogram can be a simple and definitive means of evaluation.

Indications

The indications for shoulder arthrography are: (1) rotator cuff tear; (2) subluxation of the shoulder; (3) recurrent dislocations; (4) frozen shoulder — adhesive capsulitis; (5) lesions of the biceps tendons; (6) further work-up of shoulder pain of undetermined cause.

Technique

As with all special procedures, scout films should be obtained, including internal and external rotation, axillary, and bicipital groove views.

The arthrogram tray should include sterile towels, side sheets, 20 cc glass syringe, 10 cc glass syringe, TB syringe, 1% xylocaine, 30 cc Conray, 0.3 cc of 1 : 1000 epinephrine, plastic stop cock, anesthesia extension tubing, Betadine, saline, 2 small basins, 4 × 4 gauze, hemostats, and 22 gauge 3½ inch spinal needle.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic Hospital,
Jackson, MS.

The patient is placed supine on the fluoroscopy table and the skin cleansed with Betadine. The shoulder is draped with sterile towels and sheets. Using fluoroscopy, the junction of middle and distal third of the glenohumeral joint is localized and the shoulder is placed in a neutral or mild external rotation position. The 22 gauge spinal needle is then inserted vertically into the joint space as far as it will go and then withdrawn one or two millimeters. Position is confirmed with fluoroscopy. The joint should be aspirated for fluid; then a small amount of contrast is injected under fluoroscopy to confirm position within the joint space. When the needle is in place, 10-12 cc of contrast mixed with 0.3 cc of epinephrine (to prevent rapid absorption of contrast) is injected under fluoroscopy. After the needle is removed, manipulation under fluoroscopy may be performed and spot films taken as desired. Films in the same position as the scouts are taken subsequent to fluoroscopy.

In the normal arthrogram, contrast is seen in the shoulder joint, the subcapsular bursa, the axillary fold and the bicipital groove (See Figures 1 & 2). The rotator cuff is formed by the tendons of the supraspinatus, subscapularis, infraspinatus, and teres minor muscles.

Abnormal Arthrograms

Rotator cuff tears. The subacromial bursa is located above and lateral to the greater tuberosity of the humerus. The bursa is located under the acromion and extends around the humeral head (See Figures 3 & 4). The subacromial bursa does not normally communicate with the shoulder joint and contrast within



Figure 1. Normal arthrogram.



Figure 3. Rotator cuff tear.

the subacromial bursa indicates a complete rotator cuff tear. An incomplete tear may be visible as an "ulcer crater" of contrast near the anatomic neck of the humerus, in the under surface of the rotator cuff.

Adhesive capsulitis ("frozen shoulder"). A small joint space with absent or small subscapularis bursa and axillary recess is seen in a frozen shoulder. The joint is difficult to inject and only a small amount of contrast will enter without significant pressure.

Recurrent dislocation of the shoulder. Preoperative evaluation of soft tissue injury may be helpful in recurrent dislocation of the shoulder. Anterior dislocations may cause complete or incomplete rotator cuff tears visible on arthrography. The collection of contrast is usually anterior in the axillary soft tissues. With posterior dislocations, the contrast is located posteriorly in the soft tissues, outside the capsule and

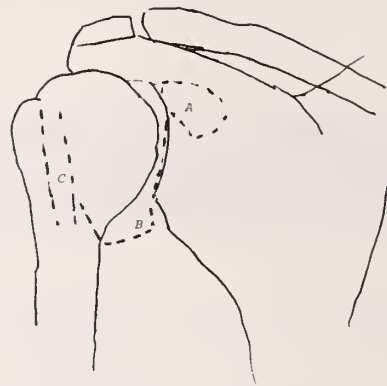


Figure 2. Normal arthrogram. (a) subscapular bursa; (b) axillary fold; (c) bicipital groove.

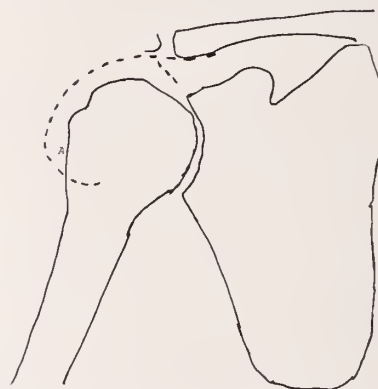


Figure 4. Rotator cuff tear. (a) subacromial bursa.

is best seen on the axillary view.

Biceps tendon injury. With rupture of the biceps tendon, contrast is seen beyond the normal synovial reflection of the long head of the biceps tendon paralleling the humerus. In subluxation of the biceps tendon, the tendon is located medial to its normal position in the bicipital groove and contrast again may be seen paralleling the humerus.

In conclusion, for evaluation of shoulder injury beyond physical exam and routine x-rays, shoulder arthrography is a safe, easily done procedure, often yielding additional information valuable to clinical management.

★★★

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Maternal and Child Health in Mississippi

ALTON B. COBB, M.D.

Jackson, Mississippi

SINCE 1979 HAS BEEN designated as the International Year of the Child, I would like to reflect on the status of maternal and child health in Mississippi. Let's consider the progress which has been made in this state in the past several years as well as the challenges which we must face in the future to insure that Mississippi has healthy children.

Infant Mortality

Whenever we address the health status of children, one of the most critical indices which must be examined is infant mortality. It not only measures the risk of infant death; it is a critical indicator of the proportion of babies who survive but with significant damage.

In 1965 Mississippi recorded 51,171 live births. Also in that year, 2,126 infants died within their first year of life, giving the state an infant mortality rate of 41.5 deaths per 1,000 live births. This rate was 68% higher than the national rate of 24.7.

The latest year for comparative data on infant mortality is 1977. In 1977 Mississippi recorded 45,532 live births and 834 infant deaths. This gave the state an infant mortality rate of 18.3, which was 30% higher than the United States rate of 14.1. This comparison shows how Mississippi's infant mortality rates have been declining at a greater rate of decline than the national rate.

The 1977 infant mortality rate for Mississippi of 18.3 was the highest for all reporting jurisdictions with the exception of Washington, DC. However, in 1977 there were 29 states with higher infant mortality rates for white infants than Mississippi, and six states reported mortality rates for black infants higher than Mississippi's rate for blacks. An additional nine states had infant mortality rates for non-whites within 1.0 point of the Mississippi rate.

It may seem incongruous for the state with the overall highest infant mortality rate to have a death

rate for white infants lower than a majority of states and a death rate for black infants lower than, or almost equal to, a fourth of the states. The reason for these relationships is the large proportion of black to white births in the state (in 1977, 23,283 white births, 22,077 black births) and the statistical weighting effect of both the Mississippi and national significantly higher rates for black infant mortality.

What about the health status of our children past one year of age? As we have described, an infant mortality rate of less than 20 means that over 98% of babies born alive are living for their first birthday.

During 1977, 143 infants and toddlers ages 1-4 died in Mississippi. The leading causes of death for these children were: accidents (56), congenital anomalies (20), and malignant neoplasms (13).

During the same year (1977) 225 children ages 5-14 died in our state — the leading causes of death were: accidents (134), malignant neoplasms (22), congenital anomalies (10), and homicide (7).

For the age group 15-24 there were 661 deaths — accidents (380), homicide (88), suicide (36), and malignant neoplasms (31).

Child Mortality

This review of post-infant and children mortality in Mississippi shows that accidents represent the leading cause of death for this age group with congenital anomalies and cancer next for the very young children, followed by homicide and suicide for our older children.

We should consider what approaches could be taken to reduce these losses of infants, children, adolescents and young adults. The major causes — accidents, congenital anomalies, malignant neoplasms, suicide and homicide — do not lend themselves to control through basic traditional preventive or treatment health service systems. There are some available preventive strategies for these causes which are not currently being fully employed. Such interventions could include mandatory rubella immunizations; safety measures for children as passengers in automobiles; reduction of automobile

Address presented by Alton B. Cobb, M.D., State Health Officer of Mississippi, at the annual meeting of the Mississippi Public Health Association in Jackson, Mississippi, December 6, 1979.

accidents through enforcement of speed limits and stricter controls over automobile drivers caught driving under the influence of alcohol. It is doubtful that our efforts at improving access to traditional health care as a desirable social goal will impact significantly on reducing these losses of life among our children and young adults.

Within particular areas of Mississippi we have seen great progress in the improvement of infant mortality rates. In 1974 the first district-wide maternal and child health project was initiated; this was the Perinatal Demonstration Project in Public Health District III (Lee and seven surrounding counties). This project strengthened the key elements in a perinatal district-wide service program. It involved health departments, private physicians and hospitals in the area.

In examining the trends of the infant mortality rates of the eleven public health districts from 1965-77, some interesting comparisons can be made. Before the implementation of the District III Perinatal Demonstration Project in 1974, the infant mortality rate had been declining in District III, as it had been statewide, but much slower than in any of the other ten health districts. From 1974-77, however, a dramatic change occurred. During this period the rate of decline in infant mortality in District III surpassed that of every other district. The same change occurred in immaturity rates, too; during 1974-77 the rate of decline in immaturity rates in District III was more than twice that of the district which had the next fastest decline. Since immaturity is the basic underlying cause of infant mortality, this change is most significant.

Significant Improvements

As you can see, the status of infant health in Mississippi has improved significantly during the last decade. Public health services have played a large part in contributing to this improvement.

A major source of basic preventive care, including health assessments, particularly in low income mothers and babies in this state, is the network of county health departments. In fact, approximately one third of the state's maternity patients receive prenatal care annually through the local health departments. Under Title V Maternal and Child Health (MCH) and other federal project funding, we offer an extensive array of services.

In addition to basic services under MCH funds, the improved pregnancy outcome projects (an extension of the perinatal demonstration project mentioned earlier) and the improved child health projects

are targeted toward high risk patients. Other perinatal projects include those in Holmes and Bolivar Counties as well as the Central Maternity and Pediatric Clinic in Jackson and the Children and Youth Clinic in Vicksburg.

In addition to MCH and project funds, we annually program about \$300,000 in state funds into high risk maternity care and another \$100,000 into high risk infant transport between community hospitals and perinatal centers. These funds provide payment of services for the high risk patient who has no other resources.

Other programs which contribute to our declining infant mortality rates and improved maternal and child health are: family planning; the Women, Infants and Children Supplemental Food Program (WIC); and the developing system of perinatal centers in our state.

The statewide family planning program is at present serving 65,000 women, of whom 21,000 are teenagers. Family planning nurse practitioners and nurse midwives provide over half of the clinical services for these individuals. We are currently serving almost half of the estimated number of women in need of these services.

The WIC program provides supplemental foods and nutrition counseling to almost 50,000 pregnant and lactating women, infants and children in 52 counties. Mississippi provides services to a larger percentage of its WIC target population than any other southeastern state.

The immunization program has also contributed significantly to improved child health in Mississippi. Our state boasts a record of having 98.9% of school age children immunized against polio, measles, rubella, diphtheria, tetanus, and whooping cough. The number of measles cases has declined dramatically in the last year — from 214 cases in 1978 to 28 cases in 1979. The compulsory immunization law passed in 1978 is a strong contributing factor to these improvements.

We have also seen during the last decade an increase in the number of deliveries by trained health professionals — physicians and nurse midwives. During 1977, only 361 births (less than one percent of all births) in Mississippi were attended by granny midwives.

The numbers and geographical distribution of obstetricians, pediatricians, family physicians, and nurse practitioners are improving in our state. The state and local health departments employ about 75 nurses in expanded roles, and approximately 70 more nurse practitioners are working outside the health department system. The rural health clinics

which have developed recently utilize nurse practitioners extensively. In addition, 400 public health nurses staff our health departments. These nurses, along with an expanding staff of nutritionists, are key figures in the provision of services to mothers and children.

Regionalization Project

Another trend which has developed during the past several years is that toward a regionalized system for perinatal services. Regionalization involves a statewide network of hospitals providing three levels of care. The system provides coordination of services among the primary and secondary perinatal centers across the state and around the tertiary center (University Medical Center) in Jackson. We are developing an extended system of care, linking the health departments and other providers of perinatal services with these centers. This system involves the provision of risk identification, patient followup, and education, along with referral and patient tracking to the appropriate level of care. Through this regionalized system we hope to insure that no infant in Mississippi dies because of inaccessibility to care.

We have come a long way in Mississippi toward improving maternal and child health. However, we still have many problems affecting the mothers, infants and children of this state.

Mississippi still has the highest overall infant mortality rate of any state in the union. As stated earlier, our rate is primarily a reflection of our racial composition and the significantly greater risks of dying that nonwhite infants face anywhere in our country, including Mississippi. In Mississippi and the nation as a whole, the rate for nonwhite infants is twice that for white infants. As long as this differential exists, Mississippi will no doubt continue to report one of the highest infant mortality rates among the states. Immaturity rates are also significantly higher for nonwhite infants.

It is significant to note that although Mississippi's infant mortality rate is declining, the rate of decline has slowed. In some areas of the state the trend of infant mortality rates in recent years has actually been upward.

In Mississippi the leading causes of infant deaths, especially during the neonatal period, are congenital anomalies, immaturity, and respiratory problems. Influenza and pneumonia, along with diarrheal diseases and sudden infant death syndrome (SIDS) become prominent in the post-neonatal period.

As mentioned earlier, all but a handful of mothers deliver their babies in a hospital with a medical attendant. Medicaid, private insurance, and the spe-

cial funds to purchase care for the high risk patients assist many, but an estimated 30% of mothers still have no third party funds and very limited private resources. Women without financial resources simply appear at a hospital in labor and are served. This is obviously not a system of care which provides good linkages between prenatal service and delivery or assures that women are referred to the hospital which is best prepared to care for them.

Although the number of obstetricians, pediatricians, family physicians, and nurse practitioners is increasing in the state, Mississippi still has a very low physician to population ratio. Complicating the problem even further is the fact that many physicians will not accept Medicaid patients. Medicaid reimburses physicians less than the amount that a private patient would pay, and this situation is cited by many doctors as a reason for refusing Medicaid patients. Our failure to provide obstetrical service for poor women in local hospitals is a serious problem which must be addressed soon.

Fund Existing Programs

Federal support for maternal and child health programs has provided us with the principal resources necessary to accomplish what we have to date. It is essential that such support continue if we are to keep making progress toward improving the health status of mothers and children in our state. It seems unwise to propose new programs and systems for federal support in light of the apparent overall success of existing programs and the failure to adequately fund these existing programs.

The major restriction to the extent of our programs is the lack of significant expansion of funding in recent years. The WIC program is now in 52 counties; adequate funding would allow the program to cover all 82 counties. Funds available to purchase services for indigent high risk pregnancies are not adequate to meet the needs.

Coordinate New Programs

New programs, if authorized, should be coordinated in each state with existing programs. The state should be allowed to utilize the resources to most effectively address the problems in that individual state. The health planning process should be utilized to this end.

Unfortunately, however, narrowly drawn, restrictive federal regulations limit the state's potential for the most effective programming based on sound epidemiological and public health planning principles — and often actually obstruct the coordination

and integration of the various programs. For example, the continued proliferation of Rural Health Initiatives (RHIs), primarily staffed with nurse practitioners and which have little or no coordination with existing private and public health services, represents a poor use of scarce public funds.

Furthermore, many federal programs are funded for only a limited period of time, usually three to five years, after which the program must be dropped or funded through state appropriations. Even though a program may have been proven successful, it is rare for the state to assume the funding of a program which was initially funded with federal monies.

All federal health service programs should require state and/or local matching from the start; this would involve state and local government in the planning for such activities and improve the potential for continued support as well as improved coordination and cost effectiveness of services.

The state's immunization program, which is funded jointly through federal and state funds, has been effective in raising the immunization levels of school age children and in lowering the number of

communicable disease cases. Nevertheless, the immunization levels of pre-school children are still very low in Mississippi; a survey in 1978 showed that only about 54% of the two-year-olds in this state are fully immunized. The immunization program is now directing extra effort toward this problem. However, the "immunization initiative" is no longer a high priority with the federal government and the appropriations for the immunization programs are being reduced. Therefore, if the states wish to continue the programs at present levels, they will have to increase state appropriations as the federal funds are decreased. Otherwise, the services provided through the programs will have to be curtailed. This is an excellent example of shifting federal priorities — reducing funds for a cost effective preventive service, i.e., immunizations, and increasing funds for RHIs and access to primary care.

Mississippi critically needs health education in our schools. Health education should be mandated in every school in the state. Preparation for a responsible lifestyle should be a high educational priority in the future.

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The HMO Program — An Overview

Editor's Note: The following article is based on a compilation of AMA studies and reports.

A comprehensive ten-year strategy for HMO development was announced at a 1979 HMO National Policy Conference held in Washington, D.C. Howard Veit, Director of the Office of HMOs, outlined the strategy for HMO development currently being initiated by his office.

According to DHEW, a "cost-containment HMO development strategy" was selected after considering several other objectives such as maximizing the number of operational HMOs and/or maximizing total national HMO enrollment. Under the cost-containment strategy DHEW will place a high priority on starting and expanding HMOs in "high medical care cost" cities.

The development strategy aims first at 20 cities with the highest costs, next at 19 metropolitan areas experiencing very high growth rates and finally at an additional 22 large communities with above average costs. Jackson, Mississippi has been placed in the second group and activity is presently going on towards establishment of one or more HMOs.

DHEW plans three types of HMO development: (1) expansion of existing HMOs; (2) developing new HMOs; and (3) attempting to convert fee-for-service, group practices, medical centers and hospitals into some form of HMO. According to the DHEW strategy, group model HMOs will have a priority under the cost-containment plan, but IPAs are also included in the development plan because of their much lower start-up costs.

Definition of an HMO

The 1973 Health Maintenance Organization Act (P.L. 93-222) defines an HMO as an organized, fiscally sound, legal entity, which provides and/or arranges for a comprehensive range of medical benefits, including physicians' services and hospitalization, to its voluntarily enrolled members and their families, who make (or on whose behalf is made) prearranged, prepaid fees on a period basis. The HMO is *at risk* for providing the agreed-upon services within the fiscal constraints of the agreed upon per capita revenue. It is felt that this creates efficient management (administrative and fiscal) and tight utilization review of ambulatory and in-hospital services.

Status of National HMO Program

According to the "Fourth Annual Report to the Congress" prepared by the federal Office of Health Maintenance Organizations and forwarded to Congress in March 1979, there currently exist 203 health maintenance organizations (HMOs). These HMOs serve nearly 7.5 million enrollees in 37 states (27 of these states have two or more HMOs, and six have ten or more). The distribution by type of HMO is as follows: Staff 52; Group 78; Individual Practice Association (IPA) 70; three plans are unclassified.

In a February 1, 1979 report published by the Blue Cross and Blue Shield Associations, it was reported that over the past ten years the Blues' involvement in prepaid health plans has increased to a present total of 41 Plans operating or providing services to 65 prepaid health plans. According to another report by the Health Insurance Institute, there are approximately 25 indemnity insurance companies involved in 50 operational HMOs in 26 states. The HII report also stated that insurance companies have provided approximately \$80 million in financial support to HMOs through grants and loans. Several major corporations are either involved in or are investigating involvement in HMOs. For example, DuPont, John Deere, Sears and IBM are all either in the formative stages of HMO involvement or are already offering the HMO option to their employees. Chrysler, General Motors, Ford and the United Auto Workers recently launched the Health Alliance Plan of Michigan, a Group model HMO, located in Detroit.

Physician Services Through an HMO

According to the 1973 HMO Act there are three modes of delivery of physician services through an HMO. The HMO can: (1) employ its own physicians on a salaried basis (staff model); (2) contract with one or more medical groups to provide care on a prepaid per capita basis (group model); (3) contract with an Individual Practice Association (IPA) whose physicians are generally reimbursed on a fee-for-service basis.

An IPA is a legal entity which generally is organized and operated by physicians. It provides a mechanism for physicians to collectively enter into contractual arrangements with other parties, such as an HMO, to provide medical services from their offices to a defined population. Physicians join the

IPA on an individual basis by signing a Service Agreement that among other things might prescribe the physicians' agreement to: conduct his medical practice in accordance with the purposes and policies of the IPA; comply with peer review procedures established by the IPA; and accept a portion of the financial risk for delivering medical services within a fixed budget. Membership in an IPA does not limit a physician's practice to the treatment of patients covered under an IPA contract.

Under this arrangement the HMO receives a monthly premium from the subscriber group, and in turn pays the IPA on a monthly per capita basis for physician services. Generally, as the individual IPA physicians provide services to the HMO subscribers, they submit their claims to the IPA and are reimbursed on a fee-for-service basis, which is formulated on a pre-negotiated usual, customary and reasonable fee program. The physicians usually agree to accept the IPA reimbursement as payment in full and not to bill the patient for any balance.

In most IPA arrangements, the physician agrees to assume some portion of the financial risk for delivering medical services. This risk percentage is generally 10-15% of his regular fee (which means that he agrees to accept 85-90% of his regular fee as payment in full). The portion of his regular fee not immediately distributed to him enters the IPA risk or reserve pool to provide a financial cushion. At year end, if the utilization has been within the projected parameters, the physicians may receive the balance of up to 100% of their claims, after reserve contingencies. The physician may (depending upon the IPA-HMO agreements), share in any surplus realized in hospital use days per 1,000 members; laboratory, x-ray and pharmacy utilization.

HMO Program Funding

In spite of the cost-conscious attitude which appears to pervade the 96th Congress, the Administration requested an increase of \$42 million in HMO funds for fiscal year 1980; \$74 million compared to the fiscal year 1979 appropriation of approximately \$32 million. The Administration's argument for increased HMO funding is tied primarily to promised cost savings through reduced hospitalization of HMO members.

The Administration also asked for \$16 million in supplemental appropriations for fiscal year 1979, indicating that the supplemental funds were needed to inject enough new HMO starts (ten feasibility study and six initial development grants) into the development pipeline to provide viable HMOs for

the level of funding authorized in the 1978 HMO amendments. Two million of this supplemental request was for a Management Training Program for HMO personnel, and \$8 million was requested for program support to provide various kinds of technical assistance to HMOs.

Report to Congress on HMOs

In May 1979 the General Accounting Office (GAO) issued its annual report to the Congress on HMOs. This report addressed the adequacy of the DHEW grant and loan program to HMOs and the administration of the program by the Office of Health Maintenance Organizations, and also contained an analysis of 42 HMOs that were qualified as of September 30, 1977.

The Health Maintenance Organization Act of 1973 requires GAO to evaluate the operations of selected health maintenance organizations and to report to the Congress annually. The most recent previous report was issued June 30, 1978. That report expressed concern over the financial soundness of several of the plans analyzed and stated that in general the plans had not enrolled persons broadly representative of their service areas, which they are mandated to do by Section 1301 (c) (3) of the HMO Act. The report also cited several deficiencies in DHEW's administration of the national HMO program. In spite of this somewhat negative report, the 1978 HMO amendments were passed by Congress. Responding to the 1978 GAO criticisms, DHEW implemented a more strict HMO compliance plan and reorganized the federal program.

The 1979 report indicates that a larger number of qualified HMOs — 25 of 31 — have a fair to good chance of breaking even financially within the next five years. According to the 1979 report, the most common problems in those HMOs that were experiencing financial difficulties were: (1) use of medical services was not adequately controlled; (2) revenues per member appeared to be significantly less than costs per member; and (3) an overemphasis on enrollment of new members without regard to the availability of federal loan funds.

The 1979 report credits DHEW with improving administration of the program over the past years, but cites the lack of formal grant and loan policies and regulations as a continuing problem.

HMO Industry Council

The National Industry Council for HMO Development met for the first time on January 16, 1979, in Washington, D.C. Formed under the auspices of the DHEW Division of HMO promotion, the Council's

announced function is to stimulate the private sector to develop and provide HMO information to organizations, assist the development of new HMOs in targeted cities, and recommend strategies to assist HEW in implementing its program activities. Leo Beebe, a former Ford Motor Company executive, currently the Dean of Administrative Studies at Glassboro State College, is the Council's Chairman. The Council is scheduled to meet about six times a year.

AMA-HMO Study Project

At its 1978 Annual Convention, the AMA House of Delegates (a) approved the concept of neutral public policy and fair market competition among all systems of health care delivery, and (b) requested an objective assessment of HMOs, including IPAs and other group arrangements, with respect to their impact on access, quality, and cost of health care.

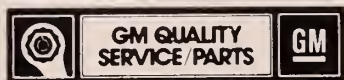
The objective assessment is now being conducted by the AMA under the direction of the Council on Medical Service. The AMA-HMO Project calls for: (1) a review of the literature; (2) HMO site visits; and (3) a final report to the House of Delegates in June 1980. ★★★

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U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Office on Smoking and Health
Public Health Service, Rockville, MD 28057



The President Speaking

All Good Things Must Come to an End

GERALD P. GABLE, M.D.

Hattiesburg, Mississippi

One of the bad things about growing older is that as we do, the years seem to pass more quickly and become so short. Such is the case with the past year, for it seems like only a few weeks ago that I accepted the presidency of our organization from Carl, and now my term has come to an end.

It has been a very brief and rewarding experience as well as an educational one, and I hope that I have justified some of the faith which you placed in me by electing me to the office. I have done some of the things which I planned to do, but as always, the clock and the calendar have seen to it that there is never enough time to do all you wish to do. I have traveled over most of the state to visit with the component societies and tried to bring you the message of what your association is trying to do for you. Conflicts in scheduling have precluded my being able to visit all of the local societies, as so many of the societies have quarterly meetings in the same months.

We have had a very fruitful year in a number of efforts — in winning our long and costly battle against the immediate past governor involving our right to appoint members to the State Board of Health; in persuading the legislature to defeat the optometry bill which would have opened the flood gates for non-physicians to practice medicine; in instituting the disabled physicians' program, and many other efforts too numerous to mention here.

Many of you have been involved in these efforts, but as we have fought these battles, I have been impressed with the dedication and effort of some of our members. But I have been concerned by the apathy of others. I feel that the largest problems which we face in our organization are apathy and lack of communication. Most of us are so busy with our practices and our families that we don't take the time to learn what is going on over the country and the world that is destined to affect our future. I can assure you that there are hundreds of thousands of people, from Washington on down, who plan to change the way you live and practice medicine. Only by shedding your apathy and becoming more involved in a united way with your peers can you abort their plans.

Let us unite in an organized medical effort as we chart the course of our ship through the turbulent seas of change which lie ahead, so that we, as professionals, can control our ship rather than leave its control to those less qualified and experienced. On behalf of my wife, Patsy, and myself, I would like to thank each of you for the many courtesies shown us during the past year. ★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 5

MAY 1980

Dangerous Vehicles

During the past six years there has been a marked increase in the use of minibikes, trailbikes, all-terrain vehicles (three similar cycles), amphibious vehicles and other small recreational vehicles in the state of Mississippi. The most recent addition to this group, the motorized water sled, is also available.

The increased use of such vehicles has been paralleled by a progressive increase in traumatic injuries associated with their use. While minor injuries are most frequent, and range from cuts and abrasions to burns and bruises, major disabling injuries are on the increase also.

The most serious injury, death, is most frequently associated with large vehicles (cars-trucks) and small vehicle collisions. However, death has occurred from complete decapitation caused by driving such vehicles under wire fences and similar obstacles. Several head and spinal injuries, fractures, facial injuries and laryngotracheal injuries have also been reported.

In many instances these vehicles are purchased by, or for, minors who have poor judgement, inadequate skills and no instruction in proper use of such a lethal machine. Improper use is not limited to the young. Many adults are injured because of improper use of these vehicles.

As physicians we should become involved by advising our patients of the hazards associated with these machines, encourage proper usage, and assist local groups in promoting safety programs or campaigns promoting proper use of small recreational vehicles.

MYRON W. LOCKEY
Associate Editor
Jackson, MS

L'envoi

Having dealt professionally with death these past forty years — preventing it if possible, postponing it if not, then finally facing it time after time after time — I now realize that I haven't faced it at all.

It was always *theirs*, easeful perhaps for the wearied old, quick and gasping for the stricken, accepted when expected with a quick transference to the waiting family, more slowly absorbed when the sudden night clangor of the telephone pierced sleep and you heard the charge-nurse's announcement, defeat seeping into your very marrow.

But still, with the stilted formalities over, you bow out, relinquishing the reins to clustered family and the inevitable obsequious funeral-home attendant. No matter how dedicated, how concerned you may be, death severs instantly the invisible thread and you fall back in skirmished retreat to begin once more your endless chosen chore.

Do we ever really accept the loss of a loved one? I think not. Enough feeling remains within our very being to keep the bond intact, to postpone our ever having to face their total removal from our scheme of things, which makes it at least bearable.

But what about this steady repetitive snatching of our colleagues from us — the grinding crunch of a locomotive, the cyanosing metamorphosis of an arrest, the deepening coma of rapid metastasis, and now the far explosion of fueled metal?

Does this not leave a peculiar void, a fraternal ache as our hopes and our pride lie with them?

ARTHUR A. DERRICK, M.D.
Durant, MS

Medico-Legal Brief

Medical-Legal Parallels

A number of trial court or appellate court decisions recently have been rendered in several cases which closely parallel Mississippi cases currently being adjudicated or cases in which medical incident reports have been filed.

Florida. In a suit in which a patient claimed that her physician negligently performed a hysterectomy so as to cause ureteral blockage and a ureterovaginal fistula the evidence did not establish as a matter of law that the patient discovered or should have discovered her injury at such time that the action was barred

by the two-year statute of limitations. Entry of summary judgment for the physician was therefore improper. — *Testone v. Adams* (Fla. App. 1979), 373 So. 2d 362.

Missouri. A jury issue of concealment of medical malpractice, such as would toll commencement of the running of the applicable limitations period, was made by a patient's allegations that a physician improperly sutured various incisions made during childbirth and thereafter repeatedly assured the patient that her condition was not unusual, did not require immediate surgical repair, and could later be cured by further suturing at the cost of \$300. — *Brewington v. Raksakulthi* (Mo. App. 1979), 584 S.W. 2d 112.

Illinois. A physician's alleged negligence in the performance of a therapeutic abortion resulting in the patient's giving birth to a healthy baby, did not, as a matter of public policy, expose the physician to liability for cost and expenses of raising a child to maturity; rather, damages would be limited to pregnancy and birth-related costs, expenses, and such associated elements of personal injury as might be pleaded by the patient. — *Wilczynski v. Goodman*, 391 N.E. 2d 479.

Minnesota. The doctrine of *res ipsa loquitur* ("the thing speaks for itself") was applicable to a spastic quadriplegic patient's suit against a physician and hospital to recover damages for unexplained burns suffered while the patient was hospitalized with a sore throat and fever. Even though the plaintiff had not eliminated all other possible causes for his lesions and the court's *res ipsa* instruction stated that the jury could not infer negligence on the part of the defendants unless it first found that the patient had suffered the burns while hospitalized, the jury's subsequent inference of negligence was thus not based on an inferred fact but on a determination that the burns had probably been suffered during the course of the hospitalization. — *Olson v. St. Joseph's Hospital* (Minn. 1979), 281 N.W. 2d 704.

(From the newsletter of the Mississippi Medical Fraternal and Educational Society.)

Constitutional Rights Don't Include Laetrile

A Federal Appeals Court has written a concluding chapter on laetrile, holding that terminally-ill patients have no constitutional right to the drug regardless of federal law.

The Supreme Court ruled last summer that dying patients are not entitled to an exemption from the

government's laetrile ban, but sent the case back to the 10th Circuit Court of Appeals in Denver, CO, to consider constitutional and statutory questions.

"If the government had lost this case, the entire drug approval system of the government would have gone right out of the window," a Food and Drug Administration spokesman said.

The Appeals Court said "the decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health."

Congress has the right to "limit the patient's choice of medication" through the Food and Drug laws, said the Court.

AHA Urges Staff Procedures

The American Hospital Association has approved a policy statement that hospital medical staffs should set up standards for people who perform health services but are neither hospital employees or members of the medical staff.

"It is essential that the appropriateness of their service or scope of activities within the institution as well as the qualifications of these individuals be evaluated by the hospital," said the AHA during its annual meeting in Washington, D.C.

The AHA said medical staff bylaws should establish procedures for:

- (1) determination of the general qualifications to be required of the non-staff employee practitioners and level of medical supervisions needed.
- (2) recommendations regarding the scope of activities for each practitioner, determined on the basis of an assessment of qualifications such as educational background, licensure, certification, experience, and demonstrated current competence.
- (3) recommendations regarding categories for appointment, performance review procedure, reappointments, disciplinary actions, and appeals procedure.

The AHA said hospital procedures should specify that the activities of the practitioners in question are to be performed in consultation with the medical staff and that they (procedures) will not be undertaken unless either (a) requested or approved by admitting or attending physicians, or (b) indicated in a protocol developed or approved by the medical staffs, and consented to by the patients.

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addic-

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

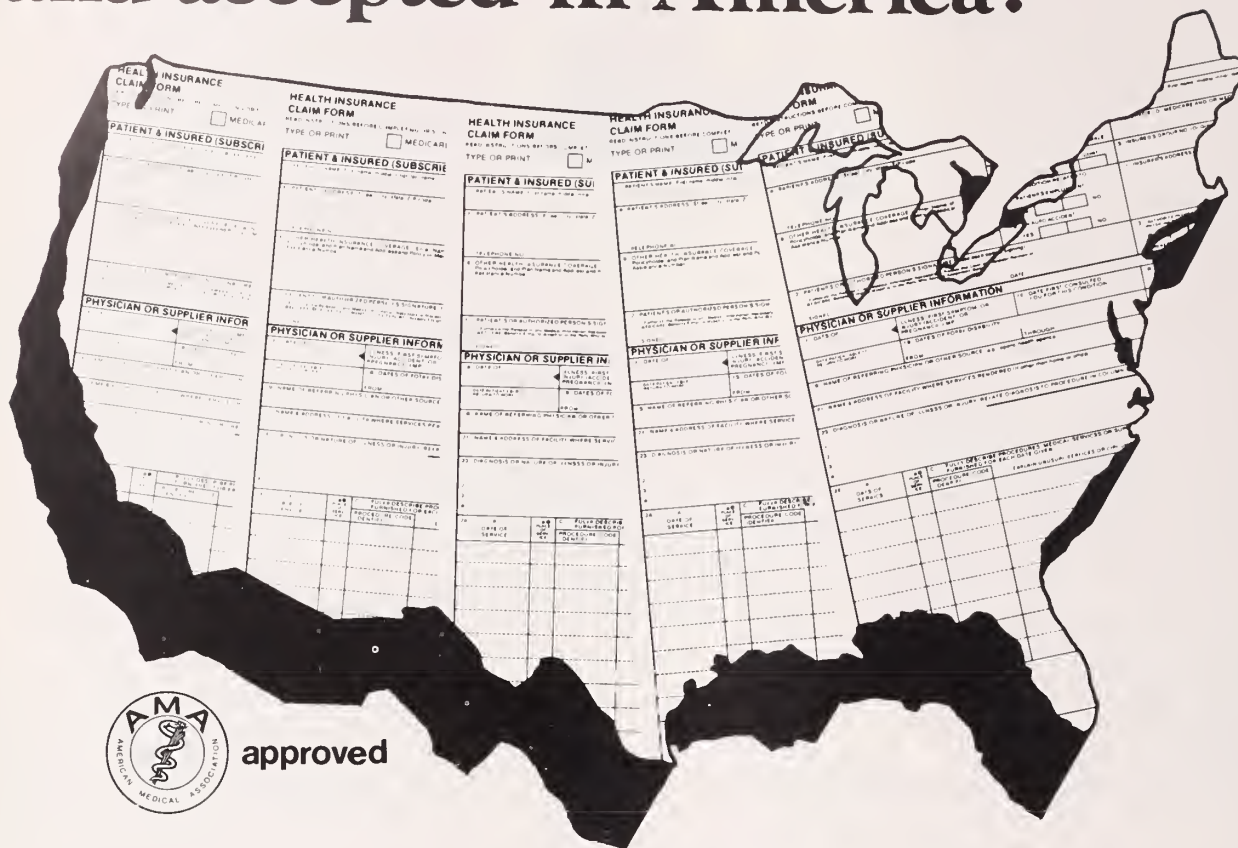
and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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The Doctor As Personnel Director

Most physicians find the loss of competent employees and the subsequent recruitment process stressful.

Recruiting and interviewing is time consuming and disruptive to your daily routine. But it's time well-spent when you consider these facts: in most practices employee salaries are the highest overhead cost; training a new employee can take anywhere from a couple of months to a year; while training, the new employee is drawing 100% salary and producing less than the other staff members; and next to your training, an efficient, personable medical assistant is your most valuable practice asset.

With these facts in mind, you should prepare necessary employee information, determine compensation levels, and take important screening steps. This will assure you of attracting first class medical assistants and prevent employee turnover.

Job Descriptions

Before advertising for a medical assistant, ask the person who is leaving to write a job description. A copy should be given to each candidate during the interview. When job requirements and duties are printed, there is little opportunity for employees to develop unrealistic job expectations leading to dissatisfaction. In addition, a job description is a valuable tool later, when you're evaluating performance for a salary review.

Be competitive regarding salary range and benefits. Find out what the local hospitals and physicians in your area are paying their medical assistants. Get information from employment agencies, laboratories and medical management consultants. If your salary range is lower, and you intend to keep it that way, consider balancing it with bonuses, vacation days, retirement plan or other fringe benefits so you can compete for talented personnel.

Policy Manual

The hiring of a new employee is an excellent reason to develop a good policy manual, if you have not already done so. A printed policy manual protects a physician from potential personnel problems. In the face of infractions you can show the disgruntled employee the limits, standards and penalties in

"black and white." If you don't establish firm ground rules, your employees will. And they may not be to your advantage. During the interview give each candidate a policy manual and allow time for questions. Eliminate the surprise element early on, and no one will be disillusioned later.

Applicants

You can begin to attract candidates by: a newspaper ad; checking community colleges offering Associate Arts Degrees in Medical Assisting; contacting professional organizations such as the American Association of Medical Assistants (write the AAMA, One East Wacker Drive, Suite 2110, Chicago, IL 60610, for a list of schools offering approved programs in Medical Assisting); or asking the personnel departments of local hospitals. In any case you should request a resume from each applicant prior to setting up an interview. You can quickly eliminate some candidates by evaluating the information contained in the resume, and checking the accuracy of typing and spelling and appropriateness of the person's background.

Although resumes are informative, data omissions frequently occur. It's practical to supplement resume information, at the time of the interview, by using an application form that complies with the equal employment opportunity guidelines. An application form is an excellent barometer of the candidate's ability to write legibly and spell.

Then, as you phone each candidate to make an appointment, continue to screen the applicants. Ask basic questions which generate sufficient conversation to make an assessment of their telephone personality. If the individual sounds unpleasant and inarticulate over the phone with you, how will they sound to your patients later? If you like the way they come across, set up a definite appointment.

Interviews

Try not to schedule too many interviews on the same day. It would be an injustice to you, your patients and the applicant to cram interviews between examinations. Designate a time before your first patient in the morning or after your last patient in the afternoon for the interview.

PRACTICE MANAGEMENT / Continued

Initial light dialogue helps to establish a relaxed atmosphere. Before the candidate arrives for the interview, choose something from the resume to generate conversation. It's your responsibility to create a neutral, nonthreatening environment. Getting out from behind your desk, offering the candidate some coffee and sitting next to the person helps to produce comfortable, "honest communication." They know you're the boss, so there's no need to intimidate them to prove the point. Tell the applicant you'd like to discuss their background and after that you will give them some information to read and to provide answers to some of their questions. Never "tip off" the candidate as to what you'd like to hear, so don't begin the interview by promoting yourself, the job and your practice.

Once you have an understanding of the candidate, decide if he or she can meet your needs. Ask yourself: "How will the candidate's character and personality blend with my practice environment and the existing mix of staff personalities?"

Checking References

Medical employment agencies say that nine out of ten physicians don't check references before they

hire and regret it later. Past employers are the only people who can tell you: "No, I wouldn't rehire them — they were late every day and absent frequently!" If time is a factor, definitely call to make reference checks. But don't rely on it entirely. People hesitate to speak frankly over the phone when they're not absolutely sure the person who is calling them is who they say they are. Written confirmation of the employee's past work experience is the alternative. Send a questionnaire form printed with your letterhead stating that the information given will remain confidential.

Keeping Good Employees

Now be decisive. Contact the most qualified candidate with the job offer, before someone else does! Finally, keep your new employees working for you by making the job as gratifying as you can. Stick to your bargain, communicate with a "thank you," regular performance reviews, educational opportunities and reasonable raises.

(Editor's Note: This month's article was prepared by Suzanne Downs, program director of AMA's Department of Practice Management. Please address your inquiries to Bucky Murphy, P.O. Box 5229, Jackson, MS 39216.)

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MEDICAL ORGANIZATION

Copiah Jail Seeks Medical Accreditation



Participating in the March 27 accreditation review of the Copiah County Detention Center were, from left, Dr. Moncure Dabney, member of the advisory committee for the MSMA Jail Health Project; Joe Rowan of Chicago, director of the AMA jail program; Ella Tardy, coordinator of the MSMA project; Dr. Fred McDonnell, the detention center physician; and Sheriff Tommy Jackson.

The Copiah County Detention Center at Gallman became the first of the Mississippi jails participating in MSMA's Jail Health Project to be inspected for medical accreditation. Results of the March accreditation review will be announced following a meeting of the AMA advisory committee in Chicago later this month.

The on-site survey included interviews with county law enforcement and jail personnel, interviews with inmates concerning medical conditions and a tour of the facility.

Joe Rowan of Chicago, director of the national program, said key factors for the evaluation of a jail health care system are access and availability of adequate health care. These are also factors which the courts stress, he added.

There are 12 Mississippi jails enrolled in the MSMA program, and all are in the process of upgrading their health care systems. Thus far, 60 jails throughout the nation have been medically accredited under the AMA program.

Rowan conducted the inspection with Dr. Moncure Dabney, a member of the MSMA advisory

committee and Ella Tardy, coordinator of the project.

Interviews were conducted with Copiah law enforcement personnel, including Deputy Richard Belding, who is in charge of the jail's health care administration, and Sheriff Tommy Jackson. Dr. Fred McDonnell, the physician responsible for the Gallman facility, jail personnel and inmates, was also interviewed.

The survey included a medical inspection and records review.

AMA Credibility Remains High

The AMA's credibility rating with the public continues high, according to a study completed last December by the Gallup Organization. The rating has declined slightly since a similar study was conducted in 1976, however.

Belief in AMA communications was rated 6.6 on a scale of one to ten, ahead of eight other professional and trade organizations and four social institutions. Only the American Dental Association, with a 6.9 rating, led the AMA.

In 1976 both the AMA and ADA had 6.8 ratings. The AMA got high marks from 41% and low marks from 12%. Only 9% were unable to rate the AMA, compared to an average of 22% for other trade and professional groups. This was considered an indication of high public awareness of the AMA.

UMC Schedules Commencement

Some 152 students in the University of Mississippi School of Medicine expect to receive the M.D. degree in Commencement ceremonies June 1 at City Auditorium in Jackson.

Governor William Winter, immediate past president of the University of Mississippi Alumni Association, will present the keynote address.

Commencement ceremonies are slated for 4:00 p.m. A reception for graduates of the UMC Schools of Medicine, Nursing, Health Related Professions, Dentistry and graduate programs in the medical sciences will begin June 1 at 2:00 p.m. at the Medical Center.

HSA Publishes MD Directory

A telephone-book size directory of Northern Virginia physicians, the most detailed directory of its type in the nation, has been published by the Health Systems Agency of the area. About half the practicing physicians submitted information for the directory, which has a cover picture of a physician holding a stethoscope to a youngster's chest.

Five thousand copies of the 441-page directory were printed at a cost of \$25,000 to the Health Systems Agency of Northern Virginia. They will be furnished at no cost to the public. Several other Health Systems Agencies (HSAs) have also produced directories. About 36 directories of physicians have been published by various groups, including medical societies, in recent years.

The Virginia directory includes information on physicians' policies on accepting Medicaid and Medicare patients, fees for standard office visits and tests, policies on billing and insurance, office accessibility for the handicapped, and prescribing by generic name.

Information is also listed on education, certification, hospital affiliations, office hours, usual advance notice required for appointments, types of laboratory tests available in the office, foreign languages and sign language spoken by the doctor or staff, and mechanisms for handling patient inquiries and complaints about billing.

The directory presents information about the Health Maintenance Organizations providing health care services in Northern Virginia, and a summary of the services provided by area public health departments.

The medical societies in Arlington, Fairfax and Prince William counties helped participate in the project.

Publication of the directory was halted in order to challenge the constitutionality of the Virginia Medical Practices Act that had prohibited physicians from furnishing information for the directory. The statute was found to be unconstitutional in November, 1976.

Carter Proposes Health Cuts

President Carter asked Congress to make deep cutbacks in appropriations for health programs in his new proposal intended to balance the budget.

The Administration wants Congress to cancel various new or expanded health grants and to reduce program support for the National Institutes of Health for total savings of \$400 million next year. In addition, the revised budget seeks recisions of \$100 million in appropriations for the current fiscal year in health manpower and "discretionary health service programs."

The economy ax also would hit the Administration's request for added funds this year for new mental health and alcoholism programs. The Administration's Child Health Assurance Program, which is near final congressional action, would be held up in Congress until next year, saving an estimated \$400 million.

Carter urged Congress to delay until 1982 the effective date of legislation expanding Medicare and Medicaid benefits, cutting fiscal 1981 outlays by \$100 million. The revised budget also said that "the Administration strongly supports the enactment of hospital cost containment legislation which would save an estimated \$800 million in federal outlays in 1981."

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EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in neonatal plasma levels end in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery. Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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FOR MODERATE PAIN

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economy of a
dosage schedule of
one tablet, every four
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(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSEAGE: SYMPTOMS The manifestations of serious overdoseage with propoxyphene are similar to those of narcotic overdoseage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdoseage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, naltorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analgesic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdoseage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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PERSONALS

JAMES ACHORD of Jackson and UMC attended the February executive committee of the American College of Gastroenterology in New York.

G. WILLIAM BATES of Jackson and UMC was visiting professor at the University of North Carolina in March. He presented a paper during the American Fertility Society Annual Conference and Exposition in Houston, March 7-8.

MILAM S. COTTEN of Hattiesburg announces the relocation of his office for the practice of ophthalmology to 207 South 28th Avenue.

H. VANN CRAIG of Natchez announces the relocation of his office for the practice of general and chest surgery to the Professional Building, 131 Jeff Davis Boulevard.

GEORGE H. ELLIS announces the opening of Rankin County Minor Emergency Clinic for the practice of emergency medicine at 219 George Wallace Drive in Pearl.

CARL EVERS of Jackson and UMC attended a meeting of the Southern Group on Student Affairs March 20-22 in Memphis.

W. MEL FLOWERS of Jackson and UMC represented Mississippi in the House of Delegates of the American College of Nuclear Physicians, March 9-12 in Washington.

RAYMOND E. TIPTON, SR. has associated with Community Medical Center, P.A. (DAYTON E. WHITES, THOMAS R. SHAW, HERBERT P. KINSEY and JOHN H. BEARRY) at 307 West Dewey Street in Lucedale.

DEATHS

TAINTOR, CHARLES W., Charleston. Born Cambridge, MA, Jan. 27, 1922; M.D., University of Tennessee College of Medicine, Memphis 1946; interned St. Joseph Hospital, Memphis, one year; died March 19, 1980, age 58.

WESSON, RAY L., Biloxi. Born Meridian, MS, May 22, 1937; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned University Medical Center, Jackson, one year; general surgery residency, same, 1964-68; died March 14, 1980, age 42.

NEW MEMBERS

BARRETT, JOHN PATRICK, Jackson. Born McComb, MS, June 17, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Baylor University Medical Center, Dallas, TX, one year; orthopedic surgery residency, University Medical Center, Jackson 1973-76; orthopedic surgery residency, Georgia Baptist Hospital, Atlanta, 1976-77; pediatric orthopedic surgery residency, Scottish Rite Hospital, Atlanta, 1977-78; elected by Central Medical Society.

BROCK, J. M., JR., University. Born McComb, MS, Feb. 6, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned LSU Charity Hospital, New Orleans, one year; internal medicine residency, University Medical Center, Jackson, 1976-78; elected by North Mississippi Medical Society.

BURK, John DAVID, Tupelo. Born Kosciusko, MS, May 31, 1949; M.D., Emory University School of Medicine, Atlanta, 1975; interned University of Tennessee, Memphis, one year; medicine residency, same, 1976-77; dermatology residency, same, 1977-79; elected by Northeast Mississippi Medical Society.

CARTWRIGHT, CLIFTON CLAUDE, Booneville. Born Cleveland, MS, Nov. 1, 1953; M.D., University of Mississippi School of Medicine, Jackson 1976; interned and family practice residency, University of Tennessee, Jackson, 1977-79; elected by Northeast Mississippi Medical Society.

COOK, CHARLES ALVIN, Jackson. Born Biloxi, MS, June 19, 1946; M.D., Tufts University School of Medicine, Boston, MA, 1975; interned Boston V.A. Hospital, Jamaica Plain, MA, one year; internal medicine residency, same, 1976-77; renal fellowship, same, 1977-78 and National Institute Health Hypertension, Boston, 1978-79; masters in public health, Harvard School of Public Health, Boston, 1974-79; elected by Central Medical Society.

DARE, DANIEL PAUL, Vicksburg. Born Dover, DE, Sept. 16, 1948; M.D., Louisiana State University School of Medicine, New Orleans, 1974; interned Charity Hospital, New Orleans, one year; orthopedic surgery residency, Tulane Medical Center, New Orleans, 1975-79; elected by West Mississippi Medical Society.

NEW MEMBERS / Continued

GAINES, KENNETH JAMES, Hattiesburg. Born Yokohama, Japan, Sept. 16, 1947; M.D., University of Tennessee School of Medicine, Memphis, 1972; interned City of Memphis Hospitals, Memphis, 1977; neurology residency, same, 1974-76; elected by South Mississippi Medical Society.

INGRAM, FRED H., Jackson. Born Greenwood, MS, Dec. 7, 1948; M.D. University of Mississippi School of Medicine, Jackson, 1968; interned University Medical Center, Jackson, one year; ob-gyn residency, same, 1969-72; elected by Central Medical Society.

MANGREM, CAROLE LYNN, Clarksdale. Born Albuquerque, NM, Dec. 17, 1948; M.D., University of Texas Medical School, San Antonio, 1974; interned University Medical Center one year; pediatric residency, same, 1975-78; elected by Clarksdale and Six Counties Medical Society.

McCLOSKEY, JOHN JOSEPH, Pascagoula. Born Pittsburgh, PA, May 21, 1943; M.D., St. Louis University School of Medicine, St. Louis, Missouri, 1969; interned University of Kentucky, Lexington, one year; neurosurgery residency, same, 1970-76; neuropathology residency, University of Miami, Miami, FL, 1976-77; elected by Singing River Medical Society.

SEPULVADO, POLLY M., Vicksburg. Born Vicksburg, MS, Nov. 25, 1949; M.D., Louisiana State University School of Medicine, New Orleans, 1974; interned Charity Hospital, New Orleans, one year; internal medicine residency, Navy Regional Medical Center, San Diego, CA, 1976-78; elected by West Mississippi Medical Society.

WELLS, PEGGY J., Born Hollandale, MS, Feb. 18, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University Medical Center, Jackson, one year; pediatric residency, same, 1975-78; elected by Clarksdale and Six Counties Medical Society.

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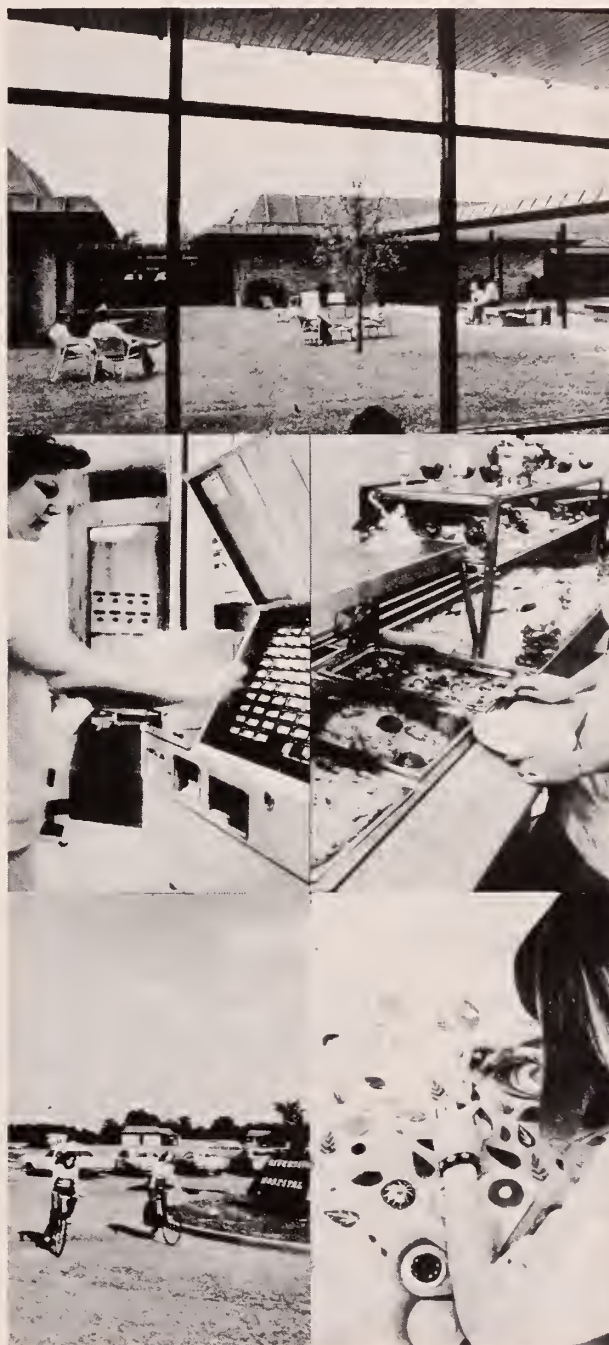
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

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Riverside Hospital

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POSTGRADUATE CALENDAR

May 6-10, 1980

USE OF ASIF/AO SMALL FRAGMENT SET IN HAND
SURGERY: PRINCIPLES AND TECHNIQUES
Ocean Springs, MS

Sponsored by the University of Mississippi School of Medicine Department of Surgery Divisions of Orthopedic and Plastic Surgery Combined Hand Service and the Medical Center Division of Continuing Health Professional Education.

Coordinator: James L. Hughes, M.D., UMC associate professor of surgery (orthopedics) and chief of the division of orthopedics.

This course will focus on the role of stabilization of fractures in hand surgery. Various techniques will be taught and open reduction and internal fixation will be discussed. Support is also provided by AO International and Synthes Ltd. Fee: \$500. Credit: 20 credit hours (.2 CEU) Category I of the Physician's Recognition Award, AMA.

May 16, 1980

LEARNING DISABILITIES CONFERENCE
Hilton, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn R. Hogan, M.D., UMC professor of pediatrics, associate professor of neurology, Division of Pediatric Neurology director and director of the pediatric electrodiagnostic laboratory.

Designed for the pediatrician and family physician, this program will focus on early recognition of children with specific learning problems. Fee: \$35 for physicians. Credit: 7 credit hours (.7 CEU) Category I of the Physician's Recognition Award, AMA.

July 16-17, 1980

NEWBORN METABOLISM: FLUIDS, ELECTROLYTES AND
NUTRITION
University of Mississippi Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, the University of Mississippi School of Nursing and the Medical Center Divi-

sion of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the Division of Newborn Medicine, School of Medicine; and Gwen Bussa, B.S.N., M.N., C.N.M., assistant professor of nursing, University of Mississippi School of Nursing and instructor in obstetrics and gynecology (nurse-midwifery) University of Mississippi School of Medicine.

This course will discuss the metabolic needs of the term and pre-term infant. It will include fluids, electrolytes and nutritional needs of the well and sick newborn on short and long-term requirements. Course is limited to 10 participants. Fee: \$50. Credit: 12 credit hours (1.2 CEU) Category I of the Physician's Recognition Award, AMA.

Faculty Appointments Are Announced

Two instructors and an associate professor have joined the School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

UMC vice chancellor Dr. Norman C. Nelson made the announcements following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. George Jaros was named an associate professor of physiology and biophysics with appointments in the UMC Schools of Medicine and Dentistry. Dr. Michele P. Johnson is new instructor in obstetrics and gynecology and Dr. John Staczek was named an instructor in microbiology.

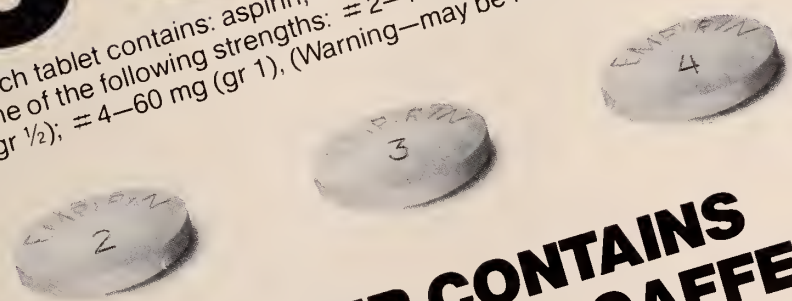
Dr. Jaros, former principal biomedical engineer in the department of biomedical engineering at the University of Cape Town, South Africa, holds the B.Sc., M.Sc. and D.Sc. degrees. He has worked at the Center of Neurochemistry in Strasbourg, France, and was senior lecturer in physiology at the University of Pretoria in 1973.

Dr. Johnson has a B.A. degree from Baylor University and the M.D. degree from the Baylor College of Medicine. She has been a resident in obstetrics and gynecology at UMC since 1975.

Dr. Staczek earned the B.A. degree at Saint Vincent College, and holds a Ph.D. from Rensselaer Polytechnic Institute. He was a 1972-1974 NEDA fellow and was a National Research Service Award fellow from 1976-1978. He took postdoctoral training at Wistar Institute of Anatomy and Biology and is former assistant professor of virology and molecular biology at Villanova Pennsylvania University.

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to business**

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

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The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

**for moderate anxiety
with depression**

dual-action
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containing perphenazine and amitriptyline HCl

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TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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for a brief summary
of prescribing information.*

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of moderate anxiety with depression

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4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema, reversed epinephrine effect, hyperglycemia, endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia, nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures, alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress; vomiting, anorexia, stomatitis; peculiar taste; diarrhea; parotid swelling, black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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RECOLLECTIONS

Twenty years ago Dr. Stanley Hill's "President's Page" outlined several predictions for the year 2010. Thirty years remain before his predictions can be judged for accuracy, but an intermediate assessment may be possible at this time.

His prophesy included the statements that tuberculosis would be an historical disease, having been eradicated by chemotherapeutic agents; abruptio placenta would be controlled by hormones; atherosclerosis would still exist but would be better controlled — the average span of life being 100 years; contact lenses would have replaced spectacles; staphylococcal infections would be controlled by 24 hours of antibiotic therapy; and carcinoma would be controlled by medical therapy, isotopes and hormones, and would have dropped to tenth place as a cause of death.

Dr. Hill also predicted that the MSMA headquarters building would be located near Ridgeland, with a landing strip for officers' space ships, the association would have 3,050 members; and the official publication would be named the *Mississippi Medical Monthly*.

The May 1960 Journal MSMA also contained these scientific articles: "Nerve Injuries of the Hand," by J. T. Davis, M.D., of Corinth; "Cerebral Palsy in Mississippi" by John G. Caden, M.D., of Jackson; and "A Double-Blind Study of Essential Hypertension" by Raymond F. Grenfell, M.D., of Jackson and James G. Hilton, Ph.D., of Milwaukee, WI.

PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

FAMILY PRACTITIONER or general practitioner with surgery interest. Free office space. Moving expenses paid. Modern 36-bed hospital with 60-bed extended care facility. Contact: Nick Wilson, Administrator, Quitman County Hospital, Box 330, Marks, MS 38646. Call collect (601) 326-8031.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

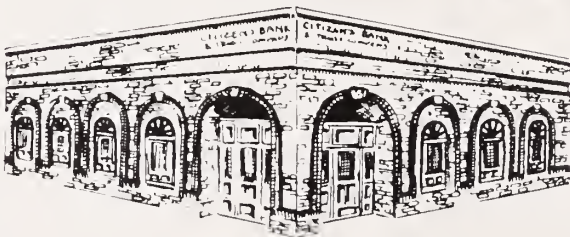
PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.


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Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

BOARD ELIGIBLE OB-GYN concluding 4-year Ob-Gyn residency July 1 seeking solo, association or partnership position in semi-rural area of Southeast. Contact: James D. Long, M.D., 131 Beverly Ave., Norfolk, VA 23505.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact

David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

CLASSIFIED

POSITIONS AVAILABLE IMMEDIATELY. The Jackson VA Medical Center is hiring physicians to work in the Admission Office. Primary care specialties (internal medicine, family practice, general practice, emergency medicine) will be given priority. Valid medical license in any state required. Regular hours, competitive salary, and liberal fringe benefits make this a particularly attractive position. Address inquiries to: William A. Causey, M.D., Chief, Medical Service, VA Medical Center, Jackson, MS 39216. Telephone (601) 362-4471, ext. 1841.

Index to Advertisers

Alliance for Health	12D
Burroughs Wellcome	12D, 112A
Canton Exchange Bank	110
Citizens Bank	114
Coca-Cola	106
Darkroom, Inc.	108
Fenwick Hall	113
Harrel Chevrolet-Oldsmobile	101
Janssen Pharmaceuticals	10, 11
Eli Lilly and Company	8
Merck Sharp & Dohme	112B, 112C, 112D

Miss. Medical Fraternal and Educational Society	20
Miss. Stationery	110
Parke, Davis	12
Premier Printing	106
Riverside Hospital	111
Roche Laboratories
... second, third and fourth covers, 3, 4, 16, 17, 104A	
William H. Rorer, Inc.	12B, 12C, 12D
Schering Corporation	6, 7
Smith, Kline & French	12A
U.S. Air Force	18
U.S. Navy	98
Wyeth Laboratories	108A, 108B
Thomas Yates	14

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ROCHE

For recurrent attacks of urinary tract infection in women

BactrimTM DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient b.i.d. dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

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Please see back cover.

Her next attack of cystitis may require

the BactrimTM

3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *bacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of colonization by fecal uropathogens. It has no significant effect on other normal, necessary intestinal

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

ALCONY

June 1980

JOURNAL of the **MISSISSIPPI** State Medical Association

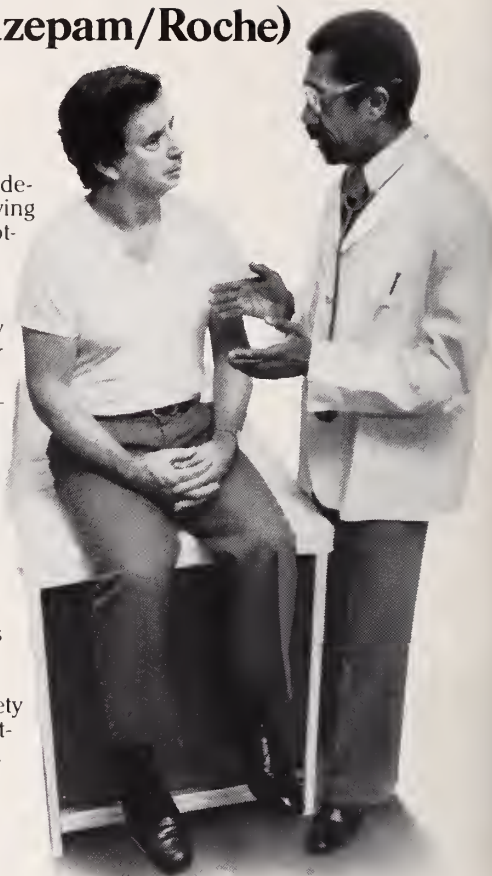
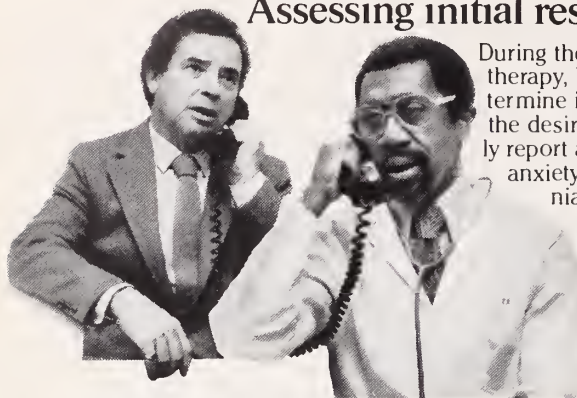


Paul H. Moore, M.D. — MSMA President, 1980-81

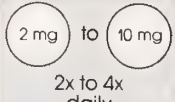

Monitoring patient response to Valium® (diazepam/Roche)

Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST
	

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

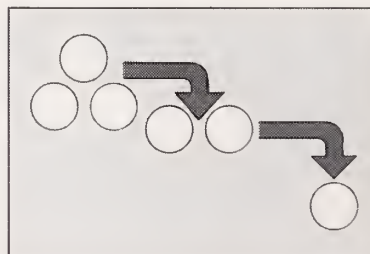
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of present-ing symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

• 2-mg, 5-mg, 10-mg scored tablets
Valium®
diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety



See the following page for a summary of product information.

Valium® (diazepam/Roche) ®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg i.i.d. or q.i.d. in first 24 hours, then 5 mg i.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg i.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg i.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Congress Studies Proposals For Health Funding Cuts

Congressional appropriations committees are considering the Administration's proposals for a further \$500 million reduction in health program funding.

The cuts in an already Spartan health budget, made as part of President Carter's all-out drive to balance the budget to fight inflation, normally would receive short shrift in Congress where health usually is treated generously. However, this year promises to be different, as Congress generally shares the Administration's concern about budget deficits.

In addition to the cuts for the fiscal year 1981 starting next October, the Administration is seeking reductions in appropriations for the current year and rescissions of appropriations already approved by Congress. Congress was asked to delay action on the \$300 million Child Health Assurance Program, originally slated to take effect next fiscal year, and on legislation expanding Medicare and Medicaid benefits. There was even a six-month postponement, until 1983, of the Administration's National Health Insurance plan.

There was little policy evident in the indiscriminate, down-the-line budget paring of health programs. Disease prevention, mental health, alcoholism, and the National Health Service Corps, not to mention the Child Health Assurance Program had all been Administration favorites.

Proposed Health, Education and Welfare cuts are as follows:

- Health Services Administration — cut by \$117 million, including \$47 million for the National Health Service Corps, \$21 million for community health centers, and \$15 million for family planning.
- Center for Disease Control — cut by \$98 million, led by \$52 million for health incentive grants.
- National Institutes of Health — cut by \$91 million plus another \$41 million from this year's appropriation.
- National Cancer Institute — cut by \$43 million.
- National Heart, Blood and Lung Institute — cut by \$15.6 million.
- Alcohol, Drug Abuse and Mental Health Administration — cut by \$102 million for state formula grants.
- Health Resources Administration — cut by \$73 million including \$38 million for local health planning.

Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by all authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

JOURNAL of the **MISSISSIPPI** State Medical Association



June 1980, Volume XXI, Number 6

ORIGINAL PAPER

- 115** Radiologic Seminar CCIII: Solitary Bone Lesion from
Unsuspected Renal Carcinoma
JOHN D. WADE, M.D.,
NANCY C. LAWHON, M.D.

SPECIAL ARTICLE

- 117** Case Report XIX of Maternal Mortality Study
W. E. GODFREY, M.D.

EDITORIAL

- 131** Member Participation Indicates Support
W. MONCURE DABNEY, M.D.

THIS MONTH

- 120** The President Speaking — Escape from the Silent
Majority Complex, PAUL H. MOORE, M.D.
- 122** Medical Organization — 112th Annual Session
- 133** Practice Management Mailbox — The Importance of
Checking References

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Federal Budget Cuts Could Endanger Health

Proposed federal budget cuts in health funding are so severe that they could compromise the health of the American people, the American Medical Association declares.

In a statement to the House Appropriations Committee of the Congress, the AMA states:

"While we recognize that governmental priorities must be established and that certain programs must be cut, we believe that other programs should be strongly supported if the health needs of the American people are to be met. We urge this Committee to consider carefully any reductions in federal funding that might compromise the health of the American people."

Funds spent on health research conducted at the National Institutes of Health are a major investment in the future health of our nation, the AMA says in urging continued support for this unit.

In the area of medical education, the AMA points out that, "With the medical sciences advancing at unprecedented rates, we believe that adequate federal support for the nation's medical schools and students is absolutely necessary in order to assure the American people the highest level of medical care possible now and in the future."

The President's revised budget recommends cuts in programs directed at improving the health status of mothers and children, but "It is most important for the future health of children that these and other programs directed to the health of mothers and children be funded and properly directed."

The AMA also urges adequate funding of the Professional Standards Review Organizations, the Food and Drug Administration, nurse training, family planning, disease prevention and alcohol abuse, drug abuse and mental health programs.

ERRATUM

Radiological Seminar CCII (page 93, May 1980 issue of JOURNAL MSMA) contained an error. The footnote should read "From the Department of Radiology, University Medical Center, Jackson, MS."

- provides effective symptomatic relief
- b.i.d. dosage simplifies therapy
- scored tablet for dosage flexibility

OPTIMINE®

azatadine maleate, 1 mg. tablets

CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children. In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and 1/2 isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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THINK DRY

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THINK
OPTIMINE[®]
azatadine maleate, 1 mg. tablets
FIRST
for relief of allergy symptoms

R_x only

Please see adjacent brief summary of prescribing information.
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ANUSOL-HC

SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

IT WAS
NUMBER ONE
IN 1959

AND IT STILL IS...

The professional source of
modern anorectal comfort

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%, bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17.5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18.0 mg, zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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2/80

NEWSLETTER

June 1980

Dear Doctor:

Successful countersuits have been upheld by appellate courts in Kentucky and Tennessee. The latter was the state's first reverse malpractice award. Dr. C. Gordon Peerman, Jr., a former president of the Tennessee Medical Association, was awarded actual damages and punitive damages following his malicious prosecution and abuse of process suit against an attorney who filed in 1974 an unsuccessful malpractice suit on behalf of one of Dr. Peerman's patients.

The Kentucky court upheld the compensatory damages awarded to an orthopedic surgeon and a radiologist in their malicious prosecution suit, but remanded the punitive damages portion to a lower court. The physicians, consultants named in a \$500,000 malpractice suit, initiated the action following their dismissal from the original suit.

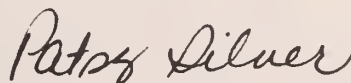
HSA funds could be cut by 30% in fiscal 1981 if President Carter and Congress accept a proposal from the Office of Management and Budget which calls for cutting the current \$124 million to \$86 million. OMB also proposed to hold funding for State Health Planning and Development Agencies to the FY80 level, and to drop a proposed \$10 million for the federal conversion/discontinuance program.

The future viability of many HSAs could be seriously compromised by the proposed reductions, says the American Health Planning Association. If the reductions are adopted, the shrinking federal support for local planning programs will be accelerated, observes the AMA's Department of Community Health Systems. (P.L. 96-79 had authorized \$165 million for HSAs and \$40 million for SHPDAs in FY81.)

The projected economic recession could increase the demand for medical services and result in higher costs, AMA's Board of Trustees chairman has told the Price Advisory Committee of the Council on Wage and Price Stability. Dr. Lowell H. Steen pointed out that past experience during recessions indicates an associated rise in utilization of health care services.

Americans continue to support voluntary contributions for congressional campaigns. The latest nationwide survey by a St. Louis based political research organization shows an increase in public disapproval of taxpayer financing of congressional elections. The February 1980 study showed that 68.2% disapprove of public funding of elections, compared to a March 1978 study which showed 67.1% disapproval.

Sincerely,



Patsy Silver
Managing Editor

More physicians *are coming to* MMFES *because MMFES does* *more for physicians.*

The active and involved physician has to rely on comprehensive insurance programs tailored to fit the day-to-day special needs of his profession.

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directed by Mississippi physicians. MMFES offers comprehensive coverage on three types of malpractice insurance policies and it'll probably cost you less than other plans.

Mike Houpt is aware of your special need. Give him a call toll free at 1-800-682-6415 or 944-0072.



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Pioneers in Medicine For the Family



BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss[®] and Ru-Vert[®]. This advertisement highlights three other products particularly useful for the family.

F-E-P CREME[®]

TWIN-K[®]

SU-TON[®]





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin — Pramoxine HCl — Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."¹

Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

¹ Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.



For the Geriatric Patient

SU-TON[®]

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol.	30 mg
Niacin.	50 mg
Vitamin B-1.	10 mg
Vitamin B-2.	5 mg
Vitamin B-6.	1 mg
Vitamin B-12.	3 mcg
Choline.	100 mg
Inositol.	50 mg
Manganese (as Manganese Sulfate).	1 mg
Magnesium (as Magnesium Sulfate).	2 mg
Zinc (as Zinc Sulfate).	1 mg
Iron (as Ferric Pyrophosphate, Soluble).	22 mg
Alcohol.	18%

See prescribing information on last page of this advertisement.

Please send me patient starter samples of:

☐ F-E-P CREME[®]

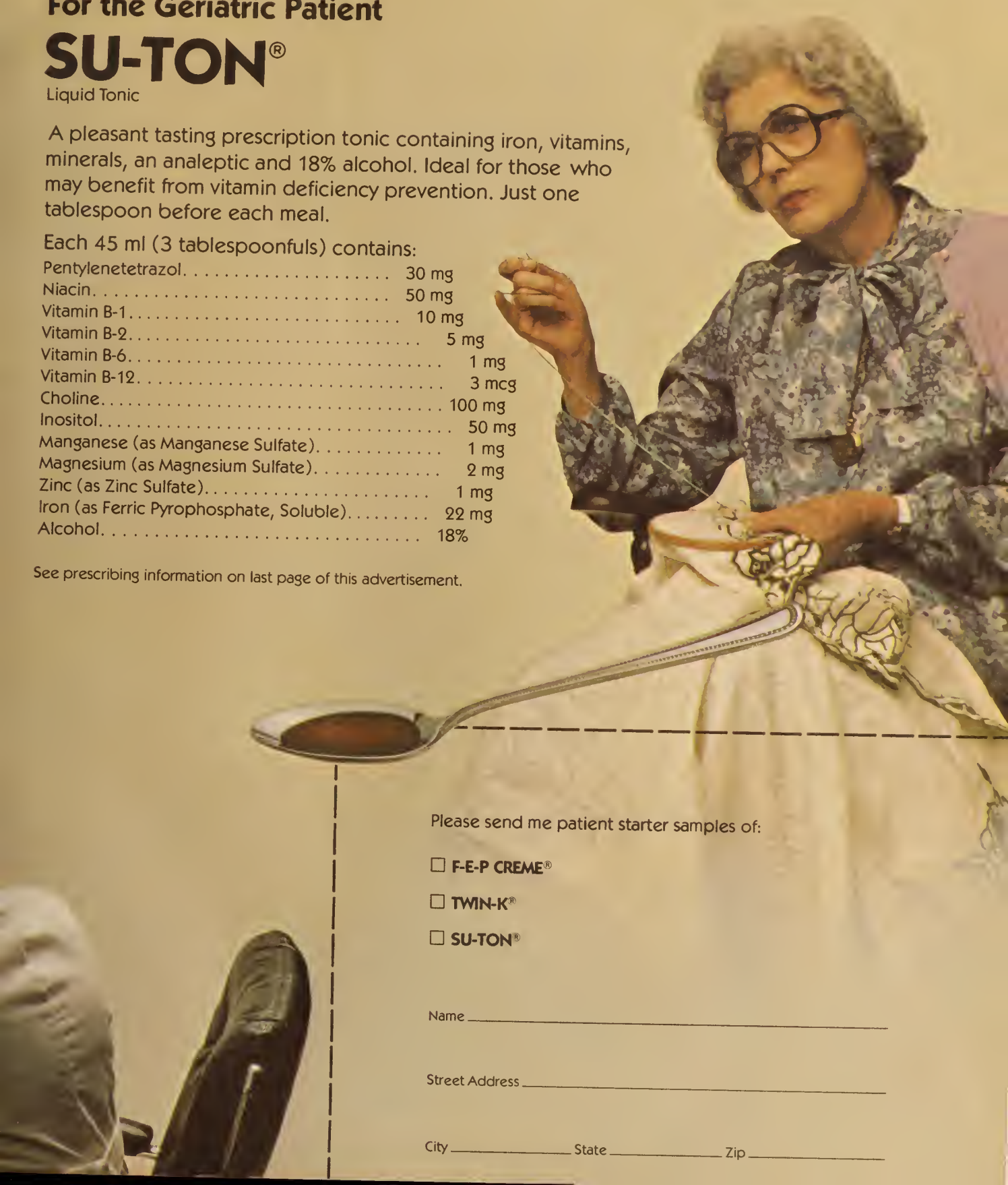
☐ TWIN-K[®]

☐ SU-TON[®]

Name _____

Street Address _____

City _____ State _____ Zip _____



F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.

2. F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 mEq/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice,

two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) or TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Choline	3 mg
Inositol	100 mg
Manganese (as Manganese Sulfate)	50 mg
Magnesium (as Magnesium Sulfate)	1 mg
Zinc (as Zinc Sulfate)	2 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an anesthetic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSE AND ADMINISTRATION: One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED: Bottles of 473 ml (16 fl oz)

NDC 0524-0015-16

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001

5-80

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MEETINGS

National and Regional

American Medical Association Annual Meeting, July 20-24, 1981, Chicago. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 1980, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 113th Annual Session, April 26-30, 1981, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1611, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. J. Barry Gilbert, Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter Dawkins, Secy., 131 Jeff Davis Blvd., Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Robert L. Coggin, Secy., 965 Avent Dr., Grenada 38901. Counties: Attala, Carroll, Choc-taw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Thomas Waller, Secy., P.O. Box 1487, Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Bruner B. Bosio, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Doug Thomas, Secy., 415 S. 28th Ave., Hattiesburg 39401. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the American Medical Association. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

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Gulf Coast Community Hospital
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Biloxi, MS 39531

Jefferson Davis Memorial Hospital
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Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
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DATELINE

Copiah Jail Wins Health Accreditation Jackson, MS - The Copiah County Detention Center has been awarded full two year accreditation by the AMA for its system of health care delivery. One of 12 Mississippi jails participating in MSMA's Jail Health Care Project, the Gallman facility is the first to receive an official review and to be granted accreditation status. The Copiah County sheriff and jail administrator worked with jail physician Dr. Fred McDonnell of Hazlehurst in implementing the model health care system.

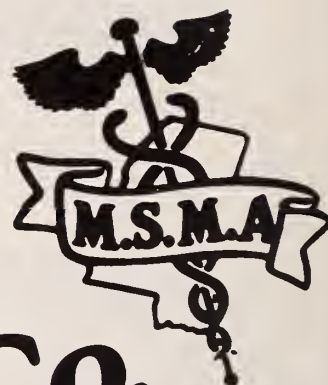
MSMA Distributes Recruitment Kits Jackson, MS - The Physician Recruitment Kit which was developed by the Council on Medical Service has been distributed to mayors, newspaper editors and Chamber of Commerce executives in small communities throughout Mississippi. The community leaders were also sent a letter regarding a proposed Physician Recruitment Symposium to be conducted in Jackson next fall. The symposium would attempt to bring together communities and physicians seeking practice locations.

Changes Suggested For NHSC Program Washington, DC - Changes are needed in the National Health Service Corps program, says Assistant Secretary for Health Dr. Julius B. Richmond. He proposes the removal of the requirement that at least 90% of the funds go to medical, dental and osteopathic students to "provide flexibility" in adapting to changing program needs. He also proposes that NHSC be permitted to limit private practice agreements and to enter into cooperative agreements with states regarding assignments.

Snake Venom Fails As ALS Treatment Chicago, IL - Snake venom has been tried and found wanting as a treatment for amyotrophic lateral sclerosis, says a Texas research report in the April issue of Archives of Neurology. A Baylor College of Medicine neurologist tested the venom with 64 ALS patients. The transient periods of improvement that are peculiar to this disease were more common in the patients receiving placebo than in those receiving venom therapy, and none of the patients showed any benefit from the treatment.

Proposed Marijuana Law May Mislead Chicago, IL - Americans may get the wrong message from proposed legislation to reduce federal penalties for possession of marijuana, the AMA told the chairman of the House and Senate Judiciary Committees. "The Congress must be especially careful not to convey to young people and their parents the message that society now sanctions marijuana use," the AMA said. "Reducing federal penalties for possession of this drug can in no way reduce the health hazards attendant on its use."

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*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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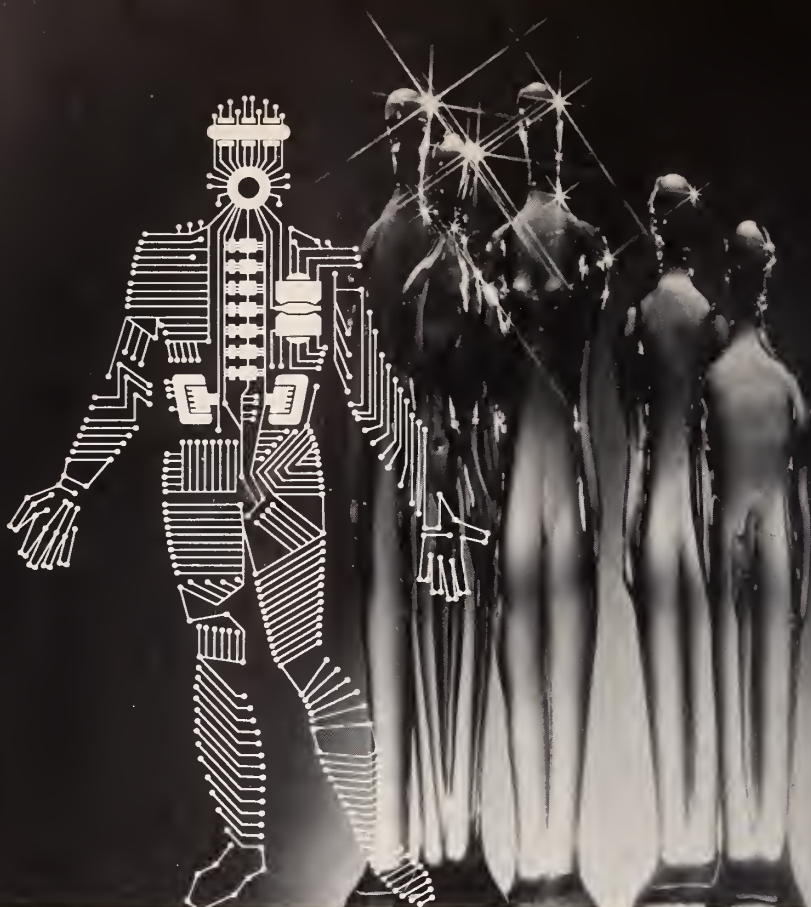
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Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg

Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdose: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdose.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

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UMC Dean Announces Faculty Appointments

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced three School of Medicine faculty appointments approved by the Board of Trustees, State Institutions of Higher Learning.

In the Department of Family Medicine, Dr. Robert Frederick Willis was named an assistant professor. Joining the Department of Obstetrics and Gynecology are Dr. Charles Edward Sampson, assistant professor, and Dr. Michele Johnson, instructor.

Dr. Willis, in private practice since 1960 in Hope Hill, NC, is a graduate of West Virginia University. He earned the M.D. degree at the Medical College of Virginia where he also held a psychiatric externship. He interned at Charleston General Hospital in West Virginia.

Dr. Sampson, on the staff of Marshfield Clinic in Wisconsin since 1970, earned the B.A. degree at Ole Miss and the M.D. degree at the UMC School of Medicine. He interned and took residency training at UMC before holding a fellowship in gynecological oncology at M. D. Anderson Hospital and Tumor Institute in Houston.

Dr. Johnson earned the B.A. degree at Baylor University and the M.D. degree at Baylor College of Medicine in Houston. She has been a resident in obstetrics and gynecology at UMC since 1975.

St. Dominic Administrator Assumes EFA Post

Sister Josephine Therese, administrator, St. Dominic-Jackson Memorial Hospital in Jackson, has recently been elected to serve on the national board of directors of the Epilepsy Foundation of America. She will serve as the Region IV director representing eight southeastern states. Sister succeeds Judge Joseph Crowell of Jacksonville, FL.

In addition to this honor, Sister was presented a plaque at the recent annual meeting of the Mississippi Council on Epilepsy for outstanding contributions to the organizations. She is a founding member and has held both board and office appointments in the Mississippi Council.

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MSMA Members Participate In CE Day at UMC



Participants in Continuing Education Day at the University of Mississippi Medical Center included, from left, Dr. James D. Hardy, UMC surgery department chairman, Dr. Norman C. Nelson, UMC vice chancellor, Dr. Elmer Nix, president of the Medical Alumni Chapter of the University of Mississippi Alumni Association, and Dr. Harper Hellems, UMC Department of Medicine chairman. Dr. Hardy and Dr. Hellems were speakers for the medical portion of the event. The Medical Alumni Guardian Society of the alumni association sponsored CE day, which featured concurrent continuing education courses in four disciplines during the day and a dinner that evening which honored 13 people in leadership during the Medical Center's early years.

Oxford Native Presents Ophthalmology Lectures



Dr. Hunter L. Little, center, clinical professor of ophthalmology at Sanford University School of Medicine and a native of Oxford, presented the Dameron Frilley Spruill and Wilma Zay Spruill Lectures in Ophthalmology at the University of Mississippi Medical Center in Jackson. Dr. Sam Johnson, left, is ophthalmology division chief at the UMC. Dr. Little's parents are Dr. and Mrs. Ashford Little of Oxford, and Mrs. Little, right, was in Jackson during her son's visit.

Recession Creates Health Demands

An economic recession will see more people visiting physicians and hospitals, the AMA has cautioned the administration.

"As unemployment levels rise, an increasing number of individuals will not have to take time off from their jobs in order to obtain medical care," noted Lowell Steen, M.D., Chairman of the AMA Board of Trustees. "In addition, experience in past recessions indicates that recently unemployed workers will try to obtain medical services before their work-related health insurance benefits expire."

Testifying before the Administration's Price Advisory Committee, Dr. Steen said that the projected recession thus could increase demand for medical services and force practice costs to rise.

Another factor to bear in mind, according to the AMA official, is that health care policy makers — including the members of the Voluntary Effort — have adopted the goal of reducing hospital utilization. "To the extent that this goal is met, it is expected that the demand for care in an ambulatory setting will increase, which, in turn, may lead to price increases for services rendered in physicians' offices."

The physicians of the nation have helped write "a real success story for voluntary restraint," said Dr. Steen. The "Physicians' Services" price index increased less rapidly than the "All-items" index of the Consumer Price Index in both 1978 and 1979.

Dr. Steen said the AMA's policies and programs represent a groundswell of physician concern for the costs faced by their own patients.

Through the years, he noted, the AMA has urged physicians to seek the most economical form of treatment consistent with good care; it has encouraged physician-patient discussion of fees prior to treatment; and it has supported voluntary health planning programs at the community level to assure appropriate distribution of health care resources.

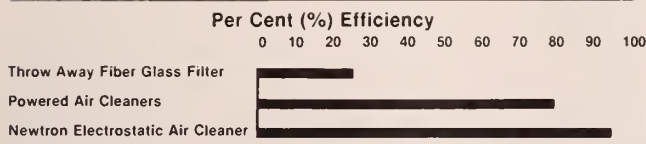
Dr. Steen concluded his testimony before the Price Advisory Committee with details of eight current AMA cost containment programs.



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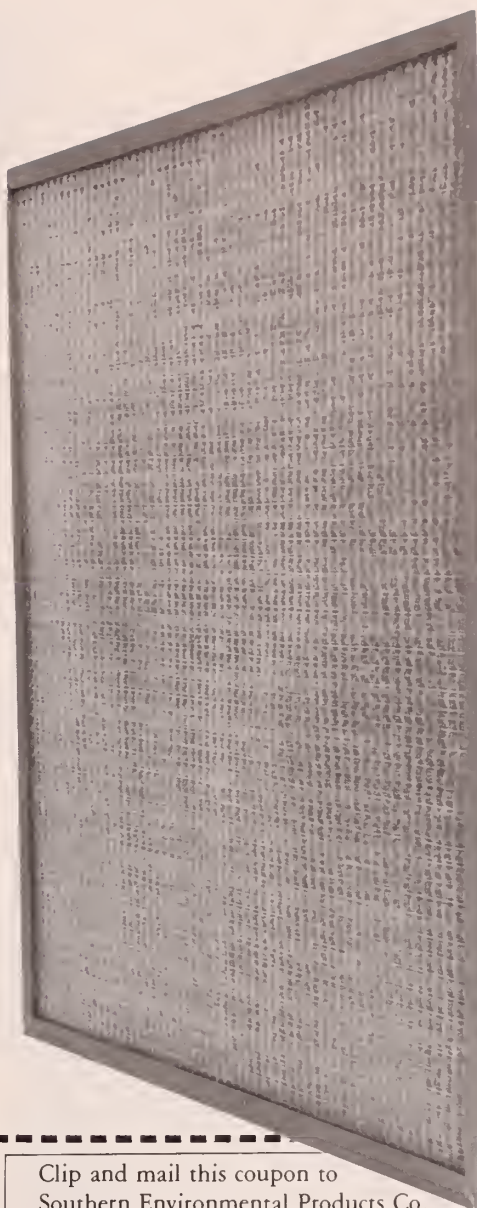
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ORIGINAL PAPERS

Radiologic Seminar CCIII: Solitary Bone Lesion From Unsuspected Renal Carcinoma

JOHN D. WADE, M.D. and NANCY C. LAWHON, M.D.
Jackson, Mississippi

PRIMARY BONE TUMORS may be encountered in patients past middle age, but the vast majority of skeletal tumors in later life will prove to be metastatic lesions. These solitary metastatic deposits are frequently the first manifestations of an occult neoplasm.

Case Report

A 72-year-old male was referred to the University Hospital for evaluation of a lytic lesion in his proximal right tibia. The only significant history was pain and stiffness related to the area of the lesion for three months. Physical examination revealed a warm, tender, fluctuant mass just below the lateral aspect of the right knee. There was a modest joint effusion in the proximal right tibia extending to the articular surface. A pathological fracture disrupted the tibial plateau (see Figure 1).

An attempted closed biopsy produced extensive bleeding and was aborted. At this point an angiogram was requested. Angiography showed a very vascular tumor with irregular and bizarre vessels and large draining veins. The appearance and clinical setting suggested renal cell carcinoma¹ (see Figure 2). A selective left renal angiogram demonstrated the small renal tumor (see Figure 3).

Further workup showed this to be a solitary metastatic deposit. Nephrectomy was performed, but the patient expired in the recovery room.



Figure 1. Lytic lesion, right proximal tibia.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, University Medical Center,
Jackson, MS.



Figure 2. Vascular lesion on arterial phase of angiogram.

Discussion

In a series of patients from the Mayo Clinic, renal cell metastases were second in frequency only to those of lung carcinoma. More than one-third of these patients with bone metastasis had this as a presenting lesion of occult renal tumors, constituting four percent of all patients with renal carcinoma. The most common site of involvement was the pelvis or lower spine, but osseous metastases may occur anywhere in the extra-axial skeleton including small bones of the hands and feet. Although most metastatic lesions occur within one to two years of the known primary, bone metastases have occurred up to 20 years after removal of the primary tumor with no apparent disease in the interim. Of 123 patients who died, only one lived five years after bone metastases were discovered.²

Nephrectomy for carcinoma of the kidney in the presence of known metastatic disease is controver-



Figure 3. Selective left renal angiogram shows tumor in upper pole.

sial. While documented cases of metastatic tumor regression after removal of the primary are most common in renal cell carcinoma, such regression remains a rarity.^{3,4}

Survival rates with nephrectomy are not significantly prolonged in patients with pulmonary or soft tissue metastases. Increased survival rates of patients with solitary bone metastasis have been reported and appear significant enough to justify nephrectomy. Nephrectomy is also acceptable for palliation of local pain or bleeding. Adjunctive hormonal and drug therapy have limited usefulness with or without nephrectomy.⁵

★★★

2500 North State Street (39216)

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Case Report XIX of Maternal Mortality Study

W. E. GODFREY, II, M. D.

Natchez, Mississippi

THE FOLLOWING case report represents a maternal death in an elderly, gravida 6, para 5 female due to rupture of uterus during oxytocin stimulation.

An elderly gravida 6, para 5 female was admitted on May 16 to a hospital labor unit. She complained of pains of 24 hours duration, but had had no bleeding or loss of amniotic fluid. She had been seen for the first time in the current pregnancy when she was about six months pregnant. Estimated date of confinement was uncertain, but she was thought to be due in late May.

Physical examination was unremarkable except for a uterus enlarged 32 cm above the symphysis pubis. Fetal heart tones were regular at 144/min in the left lower quadrant. Pelvic examination revealed the cervix to be 1-2 cm dilated and thick with vertex presenting at -3 station. Blood pressure on admission was 130/82.

The attending physician elected to begin an oxytocin drip (10 units in 1000cc D-5-W). The drip was started at 10 gtt/min and over the next few hours was increased to 30 gtt/min. No mention was made of an infusion pump or fetal monitor. About eight hours after the drip was started, the patient suddenly went into deep shock. A diagnosis of abruptio placenta was made, and the patient was given plasma expanders, whole blood, epinephrine, levophed and sodium bicarbonate. She responded not at all to these measures, and was transferred to a referral center in a nearby city.

Upon arrival at the referral center, she was rushed to surgery and emergency exploratory laparotomy was performed. A large defect in the corpus of the uterus was found, with the fetus and placenta lying free in the peritoneal cavity. She did not regain consciousness and died shortly thereafter.

Final diagnosis was cardiac arrest and hypovolemic shock due to a ruptured uterus. This case was reviewed anonymously by the Mississippi State Medical Association Committee on Maternal and Child care at a regular, quarterly meeting of the committee. The Committee felt that this death under ideal circumstances should be classified as an avoidable obstetric death due to a ruptured uterus.

Discussion

Oxytocin has become an almost indispensable addition to the obstetrician's armamentarium but, like many other medications, while a little can be therapeutic, too much can be, as in this case, fatal.

When hypotonic uterine dysfunction is diagnosed and oxytocin augmentation of labor is contemplated, among the criteria which should be met are: (1) the patient should be in true labor; (2) she should not be a grand multipara; (3) the patient should show no evidence of mechanical obstruction; (4) there should be readily available the means to treat the major complications of oxytocin stimulation; (5) there must be no history suggesting a scar in the uterus; (6) constant supervision of the patient by knowledgeable personnel should be available; and (7) positive control of the infusion rate and adequate monitoring systems should be employed.

In the case under discussion, the patient had an uncertain EDC, and with a cervix only 1-2 cm dilated and still thick she was almost certainly not in true labor. Unless there are good reasons for induction of labor, oxytocin stimulation in the face of an unfavorable cervix is distinctly unwise. In addition, if the patient is an elderly grand multipara, the logic for induction must be overwhelming.

But, occasionally in the best of hospitals with the best professional care, oxytocin stimulation results in a ruptured uterus. This can occur suddenly with no

Obstetrics and Gynecology member, Committee on Maternal and Child Care.

MATERNAL MORTALITY / Godfrey

premonitory signs or symptoms. With complete rupture, the fetus is usually lost and there is significant risk for the mother (mortality rate of 5-15%). In this instance, facilities were not at hand to deal with such a complication.

Summary

A maternal death due to rupture of the uterus

during oxytocin stimulation has been presented. Stimulation was begun in an elderly grand multipara with an unfavorable cervix in an institution lacking the facilities to deal with the major complications of the procedure. Under ideal conditions the Committee on Maternal and Child Care considers this a preventable death and urges all who employ oxytocin stimulation to review the indications and safeguards for its use. ★★★

136 Jeff Davis Boulevard (39120)

GOVERNMENT REGULATION

“I do not believe in the power of the State to plan and enforce. No matter how numerous are the committees they set up or the evergrowing hordes of officials they employ or the severity of the punishments they inflict or threaten, they can't approach the high level of internal economic production achieved under free enterprise. Personal initiative, competitive selection, and profit motive corrected by failure and the infinite processes of good housekeeping and personal ingenuity, these constitute the life of a free society.”

Sir Winston Churchill, 1945

“In 1977 alone, our research showed the price the nation paid for government regulation totaled over \$100 billion: \$470 for each person living in the U. S.; 5% of the Gross National Product; 25% of the entire federal budget; and nearly 75% of annual private investment in plant and equipment. On the federal level alone, more than \$3 billion covered the salaries and supplies of the army of 100,000 workers who staff the 41 regulatory agencies. Outlays of these agencies have increased by 100% over the past five years . . . the private sector fills out over 4,400 different federal forms each year, which last year (1977) took over 143 million man-hours at a cost of \$25 billion.”

Willard C. Butcher, 1978
(President, The Chase Manhattan Bank)

POSTGRADUATE CALENDAR

July 16-17, 1980

NEWBORN METABOLISM

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine, UMC School of Medicine, and Gwen Bussa, R.N., C.N.M., assistant professor of nursing and instructor of obstetrics and gynecology (nurse-midwifery), UMC School of Medicine.

This program will cover the metabolic needs of the term and pre-term infant. It will include fluids, electrolytes and nutritional needs of the well and sick newborn on short and long term requirements. Limited to 10 participants. Fee: \$50. Credit: 12 contact hours, (1.2 CEU) Category 1 of the Physician's Recognition Award, AMA; AAFP credit applied for.

July 18, 1980

SOUTHERN GENETICS GROUP

University Medical Center, Jackson

Sponsored by the Southern Genetics Group, the University of Mississippi School of Medicine Department of Preventive Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: John F. Jackson, M.D., professor of preventive medicine, UMC School of Medicine.

This program is the Southern Genetics Group's semiannual meeting and is open to all interested health professionals. The group is an informal association of medical geneticists who share a common interest in the understanding, teachings, diagnosis and treatment of genetic disorders. No

fee for program, \$5.00 for lunch. Credit: 4.5 contact hours (.45 CEU), Category 1 of the Physician's Recognition Award, AMA.

July 18-19, 1980

ADVANCED CARDIAC LIFE SUPPORT

PROVIDERS COURSE

North Mississippi Medical Center, Tupelo

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology, the UMC School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Roma Taylor, M.D.

This course is open to physicians, nurses and allied health personnel who are certified in basic life support by the American Health Association and who are actively engaged in advanced cardiac life support on a daily basis. Fee: \$100. Credit: Category 1 of the Physician's Recognition Award, AMA; American College of Emergency Physicians credit applied for.

FUTURE CALENDAR

October 7, 1980

MISSISSIPPI THORACIC SOCIETY MEETING

University Medical Center, Jackson

October 20-24, 1980 and January 19-23, 1981

PRACTICE OF ELECTROCARDIOGRAPHY

University of Mississippi Medical Center, Jackson

November 6-8, 1980

FAMILY PRACTICE UPDATE

Holiday Inn Medical Center, Jackson

November 14-15, 1980

NEUROSURGERY INTERNATIONAL CONFERENCE

Holiday Inn Downtown, Jackson

December 4-5, 1980

MISSISSIPPI PERINATAL POSTGRADUATE COURSE 1980

Holiday Inn Downtown, Jackson

For information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601)987-4914.



The President Speaking

Escape From the "Silent Majority" Complex

PAUL H. MOORE, M.D.

Pascagoula, Mississippi

In my initial message as your president, I would like to express to you my thanks and appreciation for the trust and honor that you have given me.

My thoughts throughout the year will be on *involvement*. We must escape from the "silent majority" complex. American medicine is no doubt the best in the world. We have the best delivery system. There is no waiting; the American public likes this. They detest waiting periods and lines.

We should be proud of the fact that we are medical doctors. Regardless of what we hear, there is always more good news than bad. We must re-assess our thinking. We must not give away any segment of medicine. There are always those groups who are willing to take anything which we will give them. Then there are those who do not wish to pay the price that it takes to become an M.D., and are most willing to give much of their time and effort to take from us by legislative action those privileges which we take for granted with our degree. We must understand that we must work harder to maintain what we have earned through education. This is not nearly as important to us as individuals as it is to the public and American medicine.

It is our duty to see that the standard of American medicine does not decline. Authorities tell us there will be a surplus of physicians by 1990. If this is the case, we must work hard with all our abilities and energies to see that medicine in the interval is not eroded by non-physicians who would like to practice medicine without education or license.

We have heard much about such subjects as Socialized Medicine, Cost of Medicine, and the Declining Image of the American Doctor. I would like to address all of these subjects briefly.

Socialized medicine has been a threat to us and the American people for some time. The reason is that there are always those who like to receive something for nothing. By the same token, there are those (politicians) who like to give away what is not theirs; however, due to a strong front put up by the AMA and its members, this has been warded off. The equality of care that we have continued to provide has also played a major role. With the cry of the American public to balance the budget, a total socialized program has probably died.

The cost of medicine is great; but, in my opinion, the cost has not increased in proportion to the quality of health care. While it would appear that the quality and services of all products has declined over the past decade, I believe we should hold our heads high and be proud of the advancement of medicine. Private health insurance may be the only bargain left in this country. Today's cost of medicine or the dollars spent on health care cannot be equated with that of yesterday, for there are so many programs and services with excellent end results being obtained, that we have no measuring stick. (Did you know that the cost of a one-page advertisement in most daily newspapers would purchase a health plan for one family for a year? How many full page ads have you seen from the tobacco industry lately?)

The image of the doctor is still good, the highest of any profession. Let's keep it that way. We need to revert back to some of the ways of the old timers. Let's get more involved in community activities. Let's get involved in civic clubs, the Chamber of Commerce, lay health programs (Cancer Crusade), local governments, and, yes, even the HSAs. Let's tell our story to all these people; they like it. Let's get to know our state legislators as well as we do our congressmen. We should get more involved in their elections. We should tell them what we, as medical leaders, know is best for the American public. Let us have issues solved before they get to Jackson. We can accomplish this by starting as soon as the legislative session is over. We already know what the issues will be next January.

The medical profession has always served the American public well. Let's strive to do even better.

★★★

Member Participation Indicates Support

Another annual meeting of MSMA has become history. The attendance was excellent, and it was my impression that the combined sessions were better received and certainly better attended. No very controversial issues were brought up, but those few which did arise were disposed of in a reasonable way.

It is always a little inspiring to me to see the number of people giving of their time and talents unselfishly in the common cause. So often, too, I hear others say they would like to participate but no one ever asks them.

You don't have to be a delegate to attend the delegates meeting, nor the reference committee. You are invited to comment on issues in the reference committee hearings. I believe if you volunteer in some capacity, most often a place will be found for you.

If you don't feel like participating in any capacity, please support MSMA and AMA. While you may not approve every action taken, they are both democratic organizations devoted to your best interest and mine.

W. MONCURE DABNEY, M.D.
Editor
Crystal Springs, MS

Book Review

What You Should Know About Medical Lab Tests. By Bernard Kliman, M.D., and Raymond Vermett. New York: T. Y. Crowell, 1979. \$9.95.

This 200-page book is the joint effort of an internist, a medical biochemist, and a free-lance writer. The book is written for the patient, rather than the physician. It is not a text to help physicians in the ordering of appropriate laboratory tests.

The writers believe, and rightly so, that with technological advances, there has been a profound increase in the number of lab tests compared to 10-15

years ago. In the vast majority of situations, the patients no longer require a simple urinalysis and hemogram. As many as 30-40 tests can be undertaken for as little as \$30.00.

The authors are well aware that the public is becoming more sophisticated and that they wish to know more about their illnesses and reasons for undertaking certain investigations. They also point out the growing trend in certain states where patients are given mini-examinations by non-physicians, with laboratory testing an integral part of this assessment. Computer print-outs, with no explanation of the results, are frequently given to these patients. This approach is not one readily accepted by the medical community; but since it is being done, this text may have particular use for that segment of the population.

The text is well-organized, easy to read, and focuses on many diverse areas, ranging from the reasons for height, weight and temperature assessment to the more complex immunoassay for hormone assessment. As one would expect, the presentation is superficial from an academic standpoint, but does stay away from outrageous statements. This is particularly evident in the chapter on vitamins.

Some information, however, does cause concern, as evidenced in the chapter on vitamins. Here it is stated that "women taking oral contraceptive pills may show decreased levels of vitamin C and various B-plex factors," the implication being that women on these hormones may need vitamin supplements. This, of course, is not current medical practice since there is no scientific evidence to justify the use of vitamins in this situation.

This book could be recommended for the stable, intelligent patient who wishes to know more about tests, and in doing so can work more closely with his or her physician in any management program outlined. Unless the physician is prepared to answer a lot of questions, it is not the type of book that one would keep in the office waiting room.

WILLIAM C. NICHOLAS, M.D.
Jackson, MS

Dr. Paul H. Moore Is MSMA President, Dr. Faser Triplett Is President-Elect

In a special election during the closing meeting of the House of Delegates, Dr. Paul H. Moore of Pascagoula was elected 1980-81 president, succeeding Dr. Gerald P. Gable of Hattiesburg. The special election was made necessary by the death of Dr. Robert S. Caldwell of Tupelo, president-elect, who would have automatically assumed the post. Dr. R. Faser Triplett of Jackson was elected president-elect.

In other elections, Dr. William B. Howard of Pontotoc, Dr. Martin H. McMullan of Jackson, and Dr. Victor E. Landry of Lucedale were named vice presidents. Dr. Moncure Dabney of Crystal Springs was elected to another term as editor of *JOURNAL MSMA*, and Dr. George H. Martin of Vicksburg was re-elected to the post of associate editor.

Dr. W. Lamar Weems of Jackson was elected to serve another term as AMA delegate, and Dr. J. Edward Hill of Hollandale was named alternate delegate.

Re-elected to the Board of Trustees was Dr. Ellis M. Moffitt of Jackson, representing District 5. Newly elected members of the Board are Dr. William B.

Hunt of Grenada, representing District 4 and Dr. George L. Arrington of Meridian, representing District 6.

Dr. W. Joseph Burnett of Oxford was elected to the Council on Budget and Finance, and Dr. George D. Purvis, Jr., of Jackson was elected to the Council on Constitution and Bylaws. Re-elected to Judicial Council posts were: Drs. L. Stacy Davidson of Cleveland, Wayne T. Lamar of Oxford and Bruce E. Atkinson of Tupelo.

Named to the Council on Legislation were Drs. Edwin M. Hemness of Clarksdale, Thomas S. Glasgow of Oxford, and Lee H. Rogers of Tupelo.

In elections to the Council on Medical Education, Dr. D. Stanley Hartness of Kosciusko was chosen to serve another term, and Drs. Wilfred R. Gillis of Jackson and Joe S. Covington of Meridian were selected to fill District 5 and District 6 posts.

Named to the Council on Medical Service were Dr. William B. Hunt of Grenada, Dr. C. David Scruggs of Jackson and Austin P. Boggan of Decatur.



Delegates elected Dr. Paul H. Moore, center, to the MSMA presidency. With him are president-elect Dr. R. Faser Triplett, left, and Dr. Gerald P. Gable, immediate past president.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL
DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] ^{CV}

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101



FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in *one* tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group. **PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients. Some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardialopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Wyeth Laboratories
Philadelphia, Pa 19101





Dr. Gable receives the past president's pin from Dr. Stanley A. Hill.

Annual Session Had Full Schedule of Activities

Some 700 physicians, spouses and guests attended the 112th Annual Session held last month at the Biloxi Hilton. This number included MSMA and auxiliary members, exhibitors, guests, students, UMC housestaff members and MSMA staff. Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly, reported that there was an increase in the number of members attending.

During the five-day meeting, three major scientific sessions were conducted under a new format introduced this year by the Council. The new format permits combined meetings of several scientific sections and calls for rotation of the groups in future meetings.

Fifteen specialty societies conducted concurrent meetings during the week. The Mississippi Academy of Facial Plastic and Reconstructive Surgery met on Sunday, as did the Mississippi EENT Association, the Mississippi Orthopedic Society, the Mississippi Chapter of the American College of Surgeons, the Mississippi Society of Anesthesiology and the Mississippi Radiological Society.

Specialty societies meeting on Tuesday included: the Mississippi Perinatal Association, Mississippi Chapter of the Association of American Physicians and Surgeons, Mississippi Chapter of the American Academy of Pediatrics, Mississippi Ob-Gyn Society, Mississippi Urological Society and Mississippi Academy of Family Physicians. Wednesday's schedule included meetings of the Mississippi Society of

Gastroenterology, Mississippi Society of Internal Medicine and Mississippi Association of Pathologists.

The Mississippi Medical Fraternal and Educational Society held its fourth annual membership meeting on Sunday, April 27, with Meridian attorney Walter Epps as guest speaker. The Mississippi Foundation for Medical Care conducted its annual meeting on Monday.

Also holding meetings during the five-day session were the Flying Physicians Association, MSMA Past Presidents and Fifty Year clubs, and medical alumni from Tulane, Arkansas and Ole Miss.

The MSMA Auxiliary conducted its 57th Annual Session, with a full schedule of business meetings and special activities.

Board of Trustees Names 1980-81 Officers

The Board of Trustees, the association's governing body, has three new members. Dr. William B. Hunt of Grenada and Dr. George L. Arrington of Meridian were elected to represent Districts 4 and 6 during the closing meeting of the House of Delegates at the recent 112th Annual Session. Dr. Roy Donald Duncan of Pascagoula was appointed to fill the unexpired term of Dr. Paul H. Moore, who was elected president of the association.

Dr. Sidney O. Graves of Natchez was elected chairman of the board. Dr. Whitman B. Johnson of Clarksdale was named vice chairman, and Dr. W. Boyce White of Laurel was elected secretary. The chairman, vice chairman and secretary make up the Executive Committee.

Dr. Ellis M. Moffitt of Jackson was re-elected to another term as trustee, representing District 5.

Continuing to serve on the Board are: Drs. W. Joseph Burnett of Oxford, William C. Gates of Columbus, and James O. Manning of Jackson, trustees; Dr. Paul H. Moore, association president; and Dr. Gerald P. Gable, immediate past president.

Six general officers meet with the board: president-elect, secretary-treasurer; speaker of the House of Delegates, vice speaker, and the two AMA delegates.

**113th Annual Session
April 26-30, 1981
in Biloxi
Mark Your Calendars Now!**

Howard K. Smith Tells MSMA Members Keys to Solving Nation's Problems

The present troubles of the United States are not insurmountable, MSMA members were told last month, as former news broadcaster Howard K. Smith outlined a program to help solve the nation's economic and foreign problems.

Speaking at the association's membership banquet held during annual session, Smith provided what he termed "a professional spectator's view," an allusion to his 40 years of experience covering national and international news.

"Our nation has faced much worse problems before," he said, citing the Great Depression and World War II as examples. While the Depression was "the most frustrating period since the Civil War," the great prosperity which followed the war produced a greater evil, according to Smith. It caused us to become spoiled and complacent. "We forgot that it took sacrifice to produce that prosperity," he said.

Resulting from that complacency has been a lack of preparedness, according to the veteran newsmen.



Howard K. Smith signs autograph for guest as Dr. Guy Vise of Meridian, left, comments on Smith's speech.

He said that a combination of mechanical accident and bad luck played a role in the failure of the mission to rescue the hostages in Iran, but he maintained that luck is largely determined by preparation and determination.

Illustrating that point, Smith stated that if he were to attempt to operate on a patient, he would surely have poor luck. "But many of you will be performing surgery in the weeks to come and you will have great luck. You're prepared." He said that America was not prepared to rescue her people. That same lack of preparedness caused us to be virtually helpless in Afghanistan, he declared.

A strong foreign policy depends upon a good home base, but the home base in the United States is eroding away. Two symptoms of that erosion, according to Smith, are inflation, which "eats away at our will," and the drop in productivity, which has not only reduced our surpluses, but has created deficits.

A look at recent history reveals factors which have long been growing, he observed.

One of those factors is the need for oil. We have produced our own oil throughout most of modern history, but last year we spent \$65 billion for foreign oil and will spend an estimated \$90 billion this year. "This is a lot of money that we need to keep in our country," Smith observed.

Other factors are the increasing demands for raw materials, resulting in higher prices, and increasing demands for food for a growing population, creating an "agricultural burden." Additionally, there are the costs of defense and the costs of cleaning up pollution.

Another factor is the gap between rich and poor. The poor are getting angry, and as in Iran, are doing radical and foolish things. Smith maintains it is in our interest that we close that gap.

Smith cited a "pension bomb ticking away in our country" as a final factor. He observed that the babies born during the "baby boom" will be 33 years old this year. When they become eligible for retirement, their pensions and Social Security costs will be tremendous, and we must be prepared for them.

In order to deal with these factors, "we must stop using our fund of national wealth wastefully," he said. First, Americans must adopt a thriftier life-

style. He pointed out that Americans waste more food than most nations eat and that we use twice the oil per capita (and waste much of it) as other nations. Secondly, he said, "we must induce government to be thriftier." He recommended the establishment of a blue ribbon commission from outside government, to make sure that the bureaucracy is run economically. He pointed to the \$7 billion per year which is wasted by the Department of HEW as an example of the need for reform, but he emphasized that he was not issuing a plea to end big government. "The free world depends on us. We have got to have big government, but government that is effective and efficient." He maintains that if every department of government were subjected to review by the outside commission, tremendous savings would result.

"We cannot pay people for doing nothing. . . . Everyone must learn that you earn your way by being competitive and productive."

"We cannot pay people for doing nothing," Smith said in a reference to government subsidies to certain businesses. Everyone must learn that "you earn your way by being competitive and productive. If an industry can't," he declared, "let it die."

Under Smith's plan of action, after conserving the wealth that we have, we must find ways to create new wealth. This can be done, he suggested, by reviving innovation, inventiveness and productivity.

"We must reward small savers," he said, observing that most capital comes from household savings, usually at a rate of three percent.

But we must stop rewarding industries for investments which do not benefit the economy, Smith said, citing Mobil Oil's purchase of Montgomery Ward as an example. "I would have taxed them to the bone," he said, emphasizing his policy of "rewarding those who produce and punishing those who don't."

Smith deplored the fact that we have become "a nation of one-year thinkers," and said that lack of planning has become a major national weakness. As an example, he noted that the energy crisis was visible for a long time. "We must stop being taken by surprise by the obvious." He proposed the development of a planning commission consisting of eight of the "best brains from academia, business

"We have become a nation of one-year thinkers. . . . We must stop being taken by surprise by the obvious."



Dr. George V. Smith and Dr. Gerald Gable speak with Howard K. Smith following the newsman's address to MSMA members.

and labor," with the members serving staggered terms.

The tremendous assets of the nation are not being fully tapped, said Smith, pointing out that the United States has the biggest skilled labor force in the world, as well as more Nobel laureates. He said we should harness this abundance of labor and brains. He reported that a California firm is building plants to liquify coal in South Africa and commented that nobody has asked that firm to build those plants for us, although the United States has the largest coal reserves in the world, along with the formula for liquifying coal.

But who is to blame for our problems and the failure to solve them? Smith said it is "the person you look at in the mirror each morning." While he admitted that he believes politicians have been very bad in recent years," he maintains that "the essential villain in a democracy is the individual." He said it is false to assume that the individual has no power. By your vote "you have the same power as the chairman of General Motors." He called upon the audience to exercise that power in elections and to unite to let congressmen know whether or not their actions are appropriate.

In a question and answer session that followed his address, Smith remarked that he believes there is a good chance the United States will win in the resolution of the Iran crisis. He said the problem is that "Iran has started a revolution and hasn't finished it yet." But he did not anticipate the release of the hostages any time soon.

Other questions concerned national health insurance, which he does not foresee for a while, and nuclear power. "Yes, it is needed," he responded, "and it is far less dangerous than people think."

Council on Scientific Assembly Will Plan 113th Annual Session

The 1981 Annual Session is set for April 26-30 in Biloxi, according to Dr. J. Elmer Nix of Jackson, chairman of the Council on Scientific Assembly. This summer the council will meet to evaluate the recent annual meeting, review preliminary plans for the 113th Annual Session and begin work on the program.

During the recent 112th Annual Session, 13 new section chairmen were named, and three section secretaries were elected. According to the bylaws of the association, section chairmen serve a term of only one year, but section secretaries are elected for three years to provide continuity. Secretaries of the sections are elected on staggered terms.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Newly elected section chairmen include: Drs. David I. Carlson of Jackson, Anesthesiology; Thomas C. Garrott of Biloxi, Dermatology; J. George Smith of Jackson, EENT; Richard M. Nowell of Jackson, Medicine; Lewis L. Lipscomb of Jackson, Ob-Gyn; Benella Oltremari of Greenville, Pathology; Mary Ward of Corinth, Pediatrics; Steve

L. Moore of Jackson, Preventive Medicine; B. Steve Smith of Jackson, Psychiatry; Vann Craig of Natchez, Surgery; Kenneth G. Carter of Jackson, Radiology; Stanley A. Wade of Meridian, Urology; and Frank Bowen of Carthage, Family Practice.

Newly elected section secretaries include: Drs. Orin F. Guidry of Jackson, Anesthesiology; Nan Brantley of Jackson, Psychiatry and W. K. Stewart of Pass Christian, Family Practice.

Remaining on the Council by virtue of unexpired terms as section secretaries are: Drs. Donald F. Baraza of Natchez, Dermatology; W. Joe Burnett of Oxford, EENT; Don Q. Mitchell of Jackson, Medicine; W. L. Kahlstorf of Tupelo, Ob-Gyn; Thomas G. Puckett of Hattiesburg, Pathology; William B. Simmons of Meridian, Pediatrics; Thomas E. Waller of Starkville, Preventive Medicine; Jerry Adkins of Biloxi, Surgery; Sandra Rhoden of Jackson, Radiology; and Ronald L. Brown of Gulfport, Urology.

Ex officio members of the Council on Scientific Assembly are the association president, Dr. Paul H. Moore of Pascagoula and the president-elect, Dr. R. Faser Triplett of Jackson.



Members of the House of Delegates assemble to conduct business.

112th Annual Session, April 26-May 1, 1980

HOUSE OF DELEGATES HANDLES BUSY AGENDA

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of reports and resolutions at the recent 112th Annual Session of the association in Biloxi. The official transactions of the meeting will be mailed to all delegates.

The MSMA House of Delegates took these major actions:

- Directed that an indepth study be made of duplication of health care planning and delivery activities between federal and state programs in Mississippi.
- Urged the state's Congressional delegation and concerned federal officials to assure that all federal funds, programs and projects for support of primary health care are allocated on the basis of greatest need and further urged them to assure that federally-supported community health centers are coordinated with existing local public and private health resources.
- Directed the association's Board of Trustees to study the current status and direction of the nurse practitioner program in Mississippi and to make recommendations in this regard.
- Urged the membership to seek out and report to the medical licensing board those physicians who have physical or emotional problems, recognizing that the medical profession has a duty to police its own ranks.
- Moved the annual session dates of the association from May to June beginning in 1984 or sooner based upon available space.
- Approved the revised "Principles of Medical Ethics" recommended by the AMA Ad Hoc Committee on the Principles of Medical Ethics.
- Endorsed state legislation to (1) reduce the retention time for x-rays from seven to four years; (2) increase the State Hospital Commission's per diem to public hospitals; (3) define brain death; (4) lower the blood alcohol content for DWI; (5) fund a statewide medical examiner system; and (6) increase health department funds for hypertension and cancer programs by placing a tax on tobacco products.
- Discontinued the technical exhibits at annual sessions in recognition of the fact that the cost to the association and to the exhibitors in conducting the technical exhibit was exceeding its benefits. A \$10.00 dues increase was authorized to fund the annual session.
- Urged the cooperation of all component societies of the association in supporting the AMA/MSMA Jail Health Care Project.
- Directed the association's Board of Trustees to investigate the feasibility of publishing a history of the association.
- Urged the Mississippi Bar Association to join the association in seeking solutions to the causes and effects of medical malpractice.
- Supported the concept of a medical Eye Safety Checklist for patients receiving an eye examination from a non-medical practitioner.

- Urged the Joint Commission on Accreditation of Hospitals to recruit surveyors from among active practitioners and expressed concern over the trend toward independence exhibited by the Commission.

- Opposed the prescribing or dispensing of medications by anyone not presently authorized by state law.

- Urged that a co-payment be required on all optional services covered under the Mississippi Medicaid program.

- Supported a study of the effects of combining the two Medicare fee areas in Mississippi.

- Amended MSMA's by-laws to provide for succession of the Speaker of the House of Delegates to the office of President-elect or President.

- Special presentation of the 1980 MSMA President's Pin to the family of Dr. Robert S. Caldwell.

- Posthumous presentation of the 1980 MSMA/Robins Award for Community Service to Dr. Jack A. Atkinson of Brookhaven. Mrs. Atkinson accepted the award.

- Presentation of \$12,769.45 to the University of Mississippi School of Medicine representing 1979 AMA-ERF contributions to the school from Mississippi physicians, alumni and their spouses.

The Reference Committee on Credentials reported seating 116 delegates at the opening session of the House of Delegates on April 28 and 115 delegates at the closing session on Thursday, May 1.

Serving on reference committees of the House were:

Reference Committee on Rules and Order of Business

Sidney O. Graves, Jr., M.D., Chairman
Stanley A. Hill, M.D.
George L. Arrington, Jr., M.D.

Reference Committee on Constitution and By-Laws

W. Lamar Weems, M.D., Chairman
Mary J. Ward, M.D.

Credentials Committee

J. Elmer Nix, M.D., Chairman
C. D. Taylor, Jr., M.D.
Matthew J. Page, M.D.

Reference Committee on Reports of Officers, Board of Trustees and Councils

David M. Owen, M.D., Chairman
Carl G. Evers, M.D.
Robert R. McGee, M.D.
William F. Pontius, M.D.
Lee H. Rogers, M.D.

Nominating Committee

Charles R. Jenkins, M.D., Chairman (District 7)
Virginia S. Tolbert, M.D. (District 1)
James W. Rayner, M.D. (District 2)
Stanley A. Hill, M.D. (District 3)
D. Stanley Hartness, M.D. (District 4)
Frederick L. McMillan, M.D. (District 5)
Stanley A. Wade, M.D. (District 6)
Louie F. Wilkins, M.D. (District 8)
Thomas R. Singley, M.D. (District 9)

**113th Annual Session, April 26-30, 1981,
at Biloxi — Mark your calendar now!**

Special Presentations Highlight House of Delegates Meeting



Above, Mrs. Robert S. Caldwell of Tupelo accepts the past president's pin from Dr. Gable during special ceremonies at the House of Delegates meeting. The memorial presentation was made in honor of Dr. Caldwell's many years of service to the association.

Below, Dr. Gable presents the 1980 MSMA-Robins Award for Community Service to Mrs. Jack A. Atkinson of Brookhaven as Robins Company representative Bob North looks on. The posthumous award recognized Dr. Atkinson's extraordinary contributions to the community and to the profession.



Dr. Joseph B. Rogers of Gulfport, left, and Dr. G. Swink Hicks of Natchez display plaques of appreciation presented to them by the MSMA Board of Trustees.



Winner of the Aesculapius Award for excellence in the MSMA scientific exhibit competition was "Care for Rheumatoid Arthritic Hands," submitted by Drs. Somprasong Songcharoen, Suthin Songcharoen and Frederick R. Heckler of Jackson.



Dr. Gable, left, presents a check to University of Mississippi School of Medicine Dean Dr. Norman A. Nelson, assisted by, at right, Mrs. Alvin E. Brent, Auxiliary AMA-ERF chairman and Dr. J. Elmer Nix, University of Mississippi Alumni Association president.

Medical Leaders Discuss Issues During Annual Session Meetings

"National Health Insurance is an idea whose time has come and gone," Dr. Tom E. Nesbitt told the House of Delegates during the 112th Annual Session.

The immediate past president of the American Medical Association told MSMA members that federal officials now see increasing competition in the medical community as a means to regulate the distribution and cost of medical care. However, he said also that the pendulum of momentum is swinging away from NHI because "people are beginning to understand what medicine has been saying for years."

Dr. Nesbitt outlined a number of issues which face the medical community and urged that physicians recognize the importance of the issues.

He encouraged physicians to participate actively in efforts to "fill the gaps in the system" and to

continue to emphasize the accomplishments of organized medicine.

He pointed to the success of the Voluntary Effort in reducing the rate of escalation in medical care costs, and he noted that "VE has bred enthusiasm" throughout the country. The benefits have not been limited to the area of costs, however; the VE has been successful in uniting all interested parties.

Dr. Nesbitt noted that there has been a profound effect on hospital-physician relations. Administrators and doctors are more aware of each other's point of view on many issues, largely due to their coalition in the cost containment effort.

Dr. Nesbitt identified the growth of non-physician providers as a major issue. Some 374,000 doctors are practicing in the U. S. today, with estimates for 550,000 by 1990; but there are many non-physicians licensed to care for patients. He noted that there are more than 17,000 chiropractors licensed in every state, and observed that state licensing prevents the American Medical Association from opposing them in court.

Dr. Gerald Gable, in his presidential address, echoed Dr. Nesbitt's plea for physician involvement.

Observing that "we are living in a very fluid and changing world, always evolutionary and sometimes revolutionary," he outlined threats to the independent practice of medicine.

He called for active participation by individual physicians in "an organized medical effort" to ensure that patients continue to have a "quality and caliber of medical care unequaled anywhere in the world."



Dr. Tom E. Nesbitt of Nashville, TN, immediate past president of the AMA, told the House of Delegates that the prospect of national health insurance is fading in favor of increasing competition in the medical community.



Delegates arrive for opening session.



Dr. and Mrs. Gable pose with daughter Eve following the President's Reception.



Dr. and Mrs. Paul Moore.

New MSMA President Active in Medical Organization

Dr. Paul H. Moore of Pascagoula succeeds Dr. Gerald P. Gable of Hattiesburg as MSMA president.

A native of Louisville, Dr. Moore received his B.S. degree from the University of Southern Mississippi, his master's degree in education from the University of Mississippi, and his M.D. degree from the University of Mississippi medical school.

He is a fellow in the American College of Radiology, past president of the Mississippi Radiological Society, and a former MSMA vice president and trustee.

He is a member of the Radiologic Society of North America, the Society of Nuclear Medicine, the Southern Radiological Conference, the American Medical Association, and Singing River Medical Society.

Dr. Moore is past president of the University of Mississippi General Alumni Association and the UM Medical Alumni Association. He is a director of the University of Mississippi Foundation and a member of the Dean's Advisory Committee, University of Mississippi School of Medicine.

A past president of the Pascagoula Rotary Club, Dr. Moore is also a member of the Pascagoula Chamber of Commerce and the Mississippi Economic Council. He is an elder in the First Presbyterian Church of Pascagoula.

Dr. Moore is married to the former Jean Mauldin of Waynesboro. They have two sons, Paul, Jr., an instructor in the radiology department of the University of New Mexico School of Medicine, and William, a University of Mississippi freshman.



Dr. Sidney Graves, Board of Trustees chairman, left, pauses with Dr. Whitman Johnson, center, and Dr. William Gates, trustees.



Officers for the Section on Ob-Gyn are Dr. Lewis L. Lipscomb of Jackson, left, chairman, and Dr. W. L. Kahlstorf of Tupelo, secretary.



Officers for the Section on Medicine are Dr. Richard M. Nowell of Jackson, left, chairman, and Dr. Don Q. Mitchell of Jackson, secretary.



Dr. Stanley A. Wade of Meridian, center, was elected chairman of the Section on Urology and president of the Mississippi Urological Society. Dr. Robert F. Carter, Jr., of Biloxi, left, is society president-elect and Dr. Ronald L. Brown of Gulfport, right, is secretary-treasurer.



Officers for the Section on Pediatrics are Dr. Robert L. Buckley of Columbus, left, secretary, and Dr. Mary A. Ward of Corinth, right, chairman. Dr. John A. Jackson of UMC, center, was speaker for the Tuesday scientific session and for the Mississippi Chapter, American Academy of Pediatrics luncheon.



Among members of MSMA's Jail Health Project Advisory Committee who met for a breakfast meeting were, from left, Dr. Virginia Tolbert of Parchman, chairman, Dr. David Steckler of Natchez, Dr. C. D. Taylor of Pass Christian and Dr. Robert Smith of Jackson.



Members of the Fifty Year Club who attended a luncheon in their honor are, from left, Dr. Lawrence W. Long of Jackson, Dr. Omar Simmons of Newton, Dr. G. T. Sheffield of Gulfport, Dr. Sam P. Caruthers of Grenada, Dr. S. Lamar Bailey of Kosciusko and Dr. Thomas F. Clay of Tutwiler.

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The AAMA pioneered in the development of curriculum standards for medical assisting programs. The American Medical Association, in collaboration with AAMA, is recognized as an official accrediting agency for such programs by the U.S. Office of Education.

On five different occasions the AMA House of Delegates has passed resolutions commending the objectives of AAMA, endorsing its functions, and urging every physician to encourage medical assistants to join the association in order to benefit from its educational programs.



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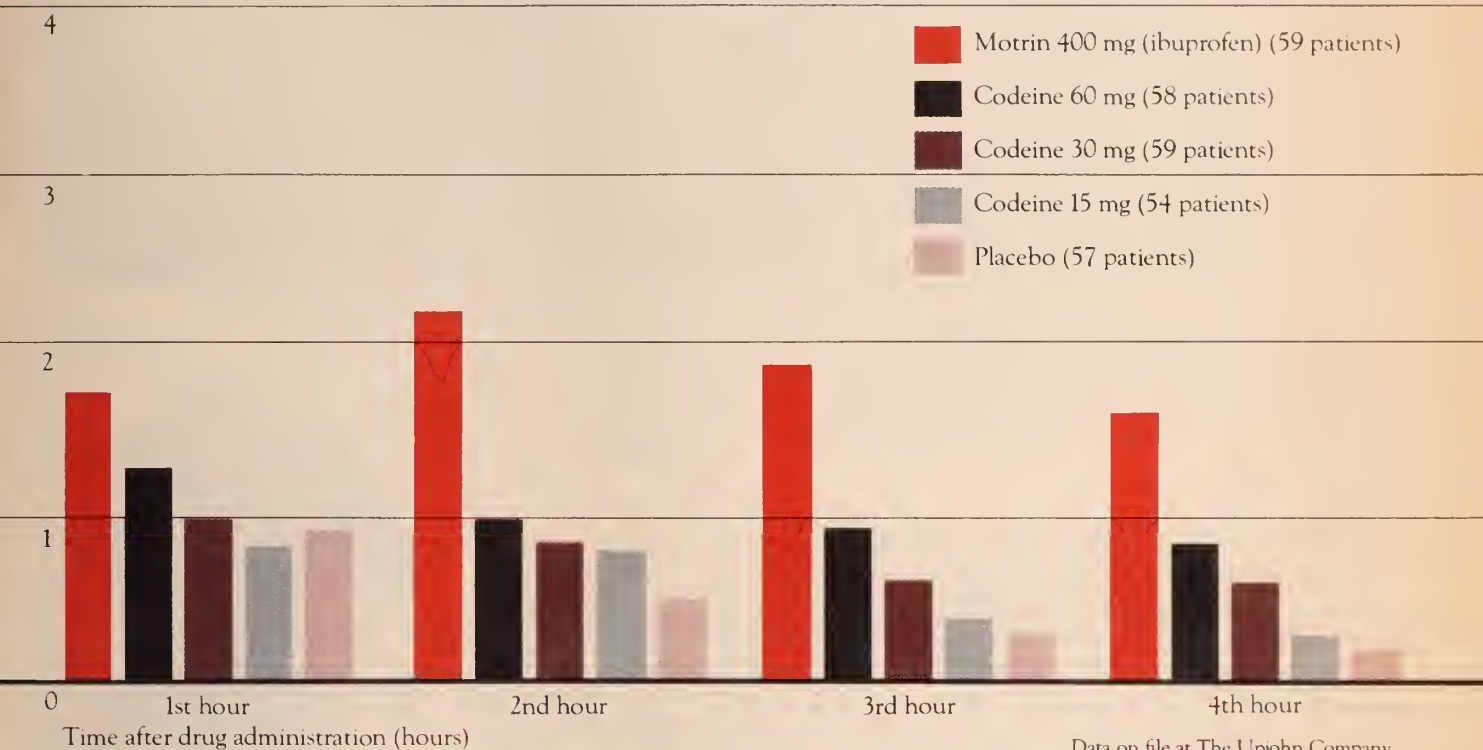
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Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

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Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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Auxiliary past presidents who attended a luncheon in their honor are: seated, left to right, Mrs. Louis Lehmann of Natchez; Mrs. Edward Hill of Hollandale; Mrs. Dan Reikes of Hattiesburg; Mrs. J. Gordon Dees of Jackson; Mrs. T. E. Ross of Hattiesburg; Mrs. T. J. Safley of Jackson; and Mrs. A. T. Tatum of Hattiesburg. Standing, left to right, are: Mrs. Stanley Hill of Corinth; Mrs. S. B. McIlwain of Pascagoula; Mrs. John Egger of Drew; Mrs. Sam Rowlett of Vicksburg; Mrs. Arthur Brown of Columbus; Mrs. Jim Barnett of Brookhaven; Mrs. S. Lamar Bailey of Kosciusko; Mrs. Joseph Rogers of Gulfport; and Mrs. Clarence H. Webb of Jackson.

MSMA Auxiliary Conducts 57th Annual Session

The general meeting of the Mississippi State Medical Association Auxiliary's 57th Annual Session took place on Tuesday, April 29, at the Biloxi Hilton. Mrs. Curtis Roberts of Brandon was installed as president, succeeding Mrs. Jim C. Barnett of Brookhaven. Mrs. John Estess of Hollandale was named president-elect.

Other officers for 1980-81 include: Mrs. James Martin of Ocean Springs, first vice president; Mrs. Stanley Hartness of Kosciusko, second vice president; Mrs. I. C. Knox, Jr. of Vicksburg, third vice president; Mrs. Ben Martin of Columbus, fourth vice president; Mrs. Stewart Williford of Hattiesburg, recording secretary; Mrs. Joe Herrington of Natchez, treasurer; Mrs. Barry B. Aden of Jackson, corresponding secretary; and Mrs. Ralph Sneed of Jackson, parliamentarian.

Special guests attending the auxiliary meeting were Mrs. Harry S. Dvorsky, first vice president of the AMA Auxiliary and Mrs. Raymond M. Yow,

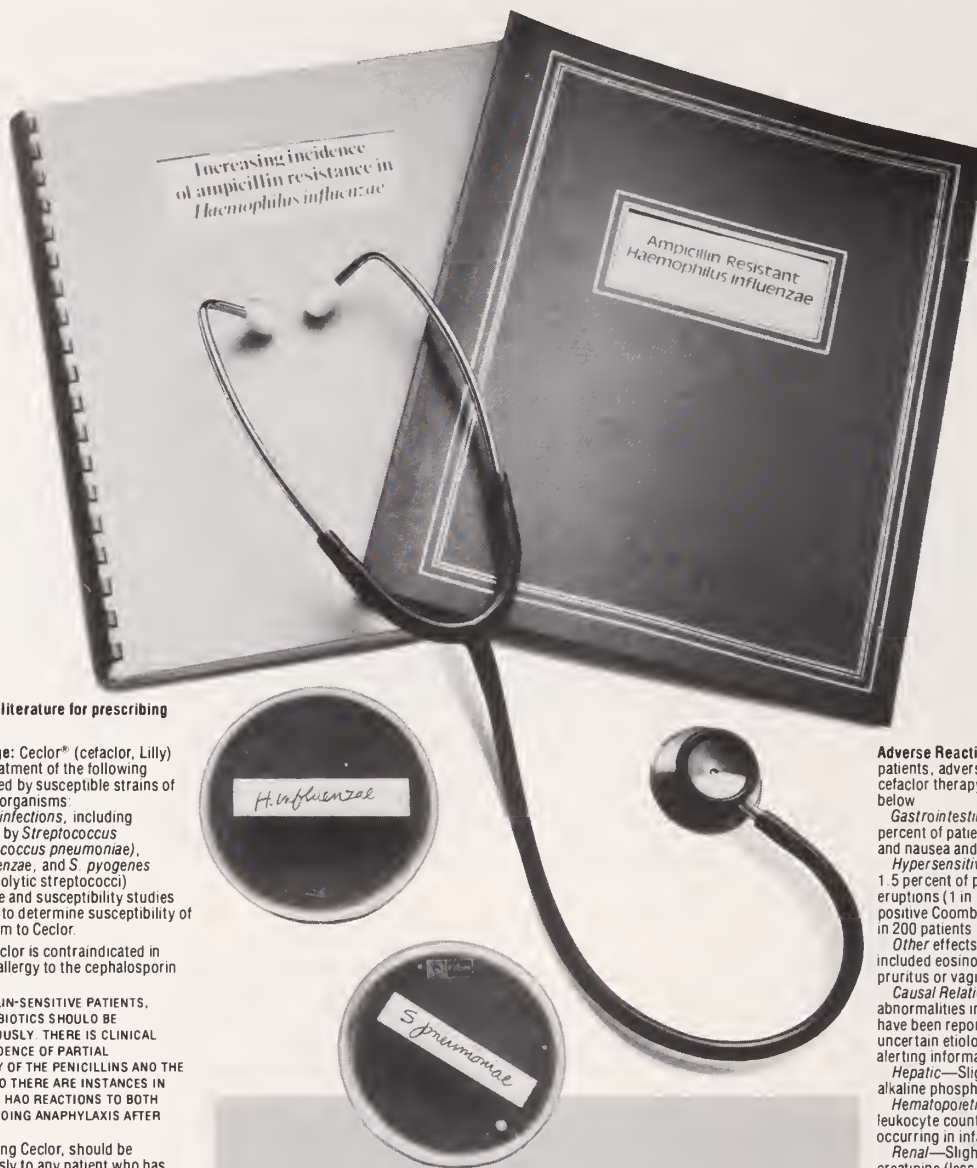
president of Southern Medical Auxiliary.

Special activities during the three-day session were a luncheon for past presidents; a lecture and display by a gemologist from the Smithsonian Institute; a coffee with Mrs. Clarence H. ("Binny") Webb, Jackson gourmet; and a special presentation of the "First Ladies of Mississippi Historical Fashion Show."



Mrs. Curtis Roberts of Brandon, president of the MSMA Auxiliary for 1980-81, told the House of Delegates of the Auxiliary's plans for the coming year.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae, and S. pyogenes (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

Ceclor®

cefactor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefactor therapy were uncommon and are listed below.

Gastrointestinal: symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.⁸

Note: Ceclor® (cefactor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II, 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

000482

The Importance of Checking References

Participants at a recent practice management workshop listened with horror to a successful physician relate his tale of having discovered one of his clinical assistants in possession of a forged license.

"She seemed pleasant enough when we interviewed her. And the past employment history she gave us was impressive. I didn't think it necessary to check with her past employers."

It wasn't long before the physician's office manager became suspicious and decided to investigate. He was surprised to find that the assistant's past references were as phony as her license. The assistant was let go without problems, but the physician admits now the incident caused him some discomfort.

Check Past Performance

Chances are a dishonest medical assistant will never find her way into your practice. But if you're like most doctors, *an incompetent or ill-mannered employee in your office may pose just as great a liability.*

Personnel professionals across the country agree: when it comes to staff performance, the best indicator of future success is past success. And that holds true for everyone in the practice from the doctor to the file clerk. While there's no guarantee that you'll ever make the "perfect hire," you can greatly enhance the possibility by checking out the past performance of all potential employees.

Problems Can Result

Unfortunately, many physicians don't check references. And many of them get burned as a result. A family practitioner we spoke to recently said he hired a new assistant on the recommendation of a past employee who had known the woman for years. When the new employee reported for work the doctor was dismayed to find that she was a terrible typist and so short tempered that he almost lost several long-standing patients.

"If I had just spent a couple of dollars to call her previous boss in California, I might have saved us both a good deal of expense and grief," he noted.

There are several points you'll want to keep in mind when checking job applicants' references. First, "personal references" will be of little value to you. Applicants have carefully chosen these individuals and you're reasonably certain to get nothing but glowing reports. Secondly, you need to have approval from applicants to contact former or current employers. Most commonly, this approval will appear as part of your job application form. If the applicant refuses to give permission, you should ask why. Often an applicant will tell you their current employer is unaware they are looking for another job. If that is the case, let the potential employee know that any final decision to hire will be contingent upon checking out that final reference. An office manager for a small group of urologists reports that she was ready to hire a new insurance clerk until a final reference check indicated termination due to excessive tardiness and absenteeism. You should also look out for any "gaps" in the past employment history. Your applicant may have spent the past two years at home raising a family. Or she may have skipped from job to job, lasting only a few months at each.

Telephone Previous Employers

In checking with previous employers, it is best to use the telephone. These days people are understandably hesitant to put negative reports in writing. And be sure to speak with the employee's past immediate supervisor, not the personnel department. Information from someone who worked side by side with the employee will be of greater value.

In chatting with that previous supervisor, it is important to keep the following thought in mind: *listen to what is not said about the applicant as well as what is said.* It is rare that anyone will say outright the employee was "lazy and ill-mannered," but they may give indications.

Personnel experts do caution, however, that it's not just the person on the other end of the phone who has to be careful about what he or she says. Just as you may not ask discriminatory questions while interviewing or on your application, don't do it when

PRACTICE MANAGEMENT / Continued

checking references. Your queries about an applicant's religion, race or family plans may just come back to haunt you. If you are in doubt about the appropriateness of your question, subject it to this test: is the information I'm after truly related to the applicant's ability to perform the job?

One question you may ask, and should ask of all previous employers is this: "Mr. Jones, if you could, would you rehire Mary Smith?"

An immediate "yes" speaks well for your applicant. A flat "no" or even a moment of hesitation may clue you into the need to look further for your "perfect hire."

Unfortunately, many past employers you will contact now have strict policies about information given over the phone. Some will only tell you how long the person was employed. Still others will tell you nothing, but will ask that you submit your reference check in writing. You may only receive verification of the information your applicant has already provided. But at least it will be enough to assure you that your applicant is telling the truth about past length of

service, job responsibilities and salary level.

One more thought to keep in mind: in a recent Texas court decision, a patient injured by an incompetent orderly successfully sued the hospital for punitive as well as compensatory damages. The hospital had not checked the orderly's references when they hired him. As a result of the suit, it was later discovered that he had been expelled from corpsman's school and had a criminal record for drug violations. The court's ruling? "Gross failure in making sure employees are qualified and trained for assigned tasks will subject a hospital to such damages." And it's not stretching the imagination to assume the same would hold true for a doctor's office.

Since employee salaries are one of the largest costs to the practice, isn't it worth your while to spend some time and effort in making the best possible hire?

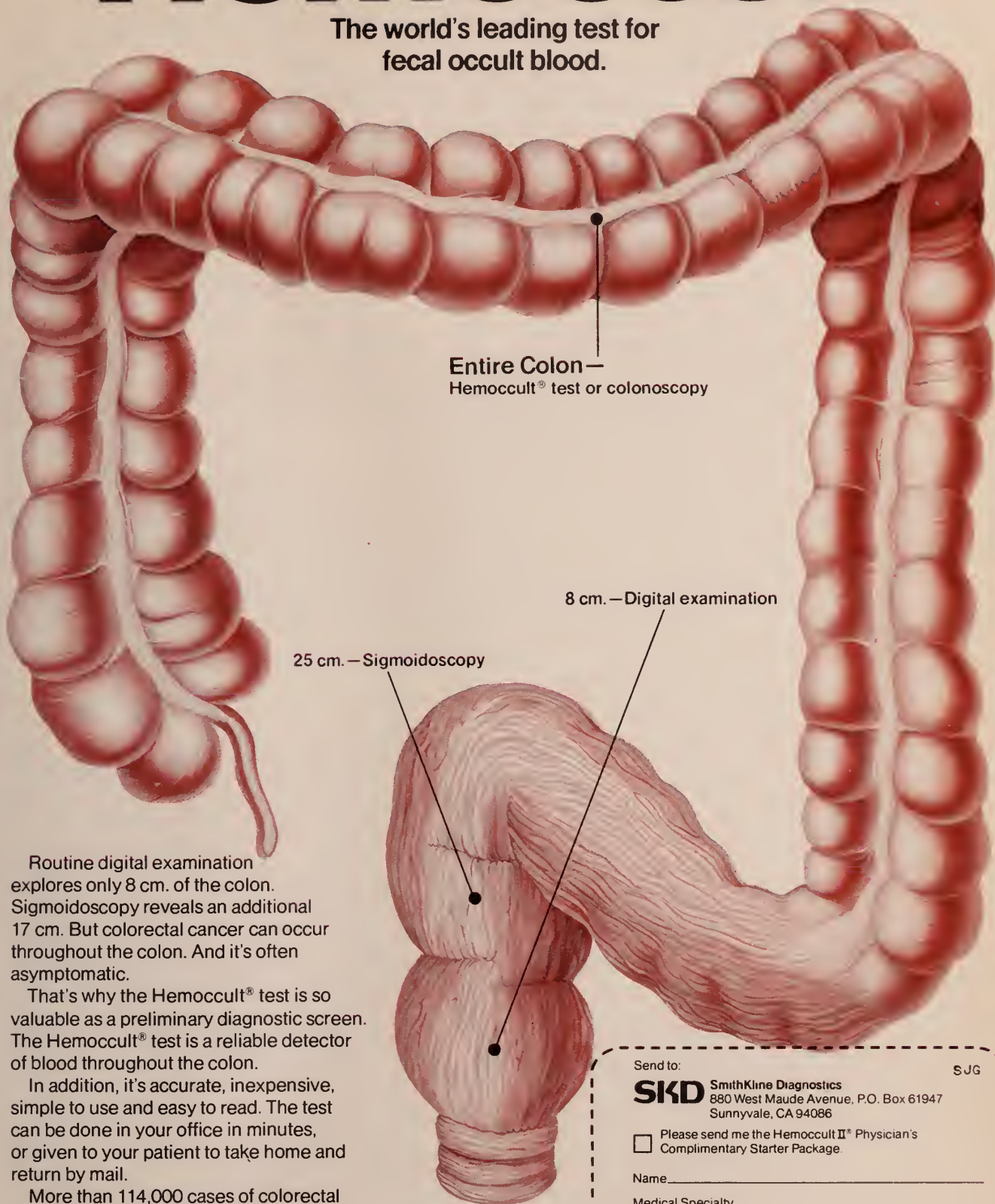
(This month's article was prepared by Lynn Dowling of AMA's Department of Practice Management. Please address your inquiries to Bucky Murphy, P. O. Box 5229, Jackson, MS 39216.)

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gently...

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Constipation



Chronic
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Laxatives



Perdiem™

Prescribing Information

ACTIONS. Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION. Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION. For relief of constipation.

PATIENT WARNING. Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) containers.

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PERSONALS

RALPH BROCK of McComb and Mrs. Brock were elected to lead Pike County Arts Council for 1980-81.

RAYMOND H. DOMINICI of Meridian announces the relocation of his office for general surgery and vascular surgery to Meridian Regional Hospital Medical Plaza, Highway 39 North.

WILLIAM W. EAST of Meridian announces the relocation of his office for the practice of ophthalmology to 1304 18th Avenue.

JAMES R. GLEAVES of Meridian has been certified by the American Board of Surgery.

MARIA I. GONZALEZ will join the staff of Franklin County Memorial Hospital in Meadville in August, for the practice of obstetrics and gynecology.

Greenville Surgical Clinic, P.A. (JOHN C. SANDEFUR and PHILIP D. DOOLITTLE) has relocated to 1214 Hospital Street in Greenville.

STANLEY HARTNESS of Kosciusko has been recertified by the American Academy of Family Physicians.

JAMES D. HARDY of Jackson and UMC recently lectured to the Alabama State Medical Association in Montgomery, Tufts University in Boston and the Tennessee Chapter of the American College of Surgeons in Nashville.

L. GERALD HOPKINS of Oxford, 1979 recipient of Mississippi Heart Association's Gold Award, has been named chairman-elect of the American Heart Association Southern Region Heart Committee.

RICHARD HUTCHINSON of Jackson and UMC spoke at

the Mississippi Heart Association meeting in Biloxi in April.

J. HARVEY JOHNSTON, JR. of Jackson was among eight honorees to receive Man of the Year Awards last month from the Total Living for Fifty Plus organization. The awards recognized high level of professional achievement and spiritual and civic contributions to community life.

HERBERT LANGFORD of Jackson and UMC recently spoke at the University of Pittsburgh in Pennsylvania, the Baptist Memorial Hospital in Memphis, Johnston-Willis Hospital in Richmond, VA, and at Yale University in New Haven, CT.

HENRY L. LEWIS of McComb has been recertified by the American Academy of Family Physicians.

MYRON W. LOCKEY of Jackson has been named president-elect of the Mississippi-Louisiana Ophthalmology and Otolaryngology Association.

ELLIS M. MOFFITT of Jackson has been elected vice chairman of the board of directors of Blue Cross & Blue Shield of Mississippi, Inc.

TOXEY M. MORRIS of Hattiesburg was elected to the board of directors of the Southeastern Section of the American Urological Association meeting in San Juan, Puerto Rico.

JOHN MORRISON of Jackson and UMC was visiting professor and guest speaker at Dalhousie University in Halifax, Nova Scotia in April.

E. LINWOOD SHANNON announces the opening of his office for the practice of obstetrics and gynecology at 710 South 28th Avenue, Suite A, in Hattiesburg.

W. LAMAR WEEMS of Jackson, secretary of the Southeastern Section of the American Urological Association, attended the recent meeting in San Juan, Puerto Rico.

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Dr. Blake Authors Electrocardiography Book

Dr. Thomas M. Blake, professor of medicine at the University of Mississippi Medical Center, has written a new book on electrocardiography for physicians and other health professionals.

Publication date for *The Practice of Electrocardiography* was March 31.

According to the publisher, the intent of the book is "to encourage physicians and students to view electrocardiograms as an understandable application of what is known about cardiac structure and function. Doctors whose EKG experience is based on pattern recognition and who are accustomed to accepting generalizations and disclaimers in their interpretations may be surprised by Dr. Blake's approach. . . ."

A member of the UMC faculty since 1955, Dr. Blake is the author of three other textbooks and more than 40 articles on heart research which have appeared in professional journals.

He is governor for Mississippi of the American College of Physicians, and on the editorial boards of Southern Medical Journal and American Heart Journal. His current clinical position is chief of the heart station.

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OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

FAMILY PRACTITIONER or general practitioner with surgery interest. Free office space. Moving expenses paid. Modern 36-bed hospital with 60-bed extended care facility. Contact: Nick Wilson, Administrator, Quitman County Hospital, Box 330, Marks, MS 38646. Call collect (601) 326-8031.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community. JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

BOARD ELIGIBLE OB-GYN concluding 4-year Ob-Gyn residency July 1 seeking solo, association or partnership position in semi-rural area of Southeast. Contact: James D. Long, M.D., 131 Beverly Ave., Norfolk, VA 23505.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

BOARD CERTIFIED PEDIATRICIAN seeks location in Mississippi. Available immediately. Contact Dayalji D. Patel, M.D., 3017 N.W. 41st Ave., Gainesville, FL 32605.

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Index to Advertisers

Boots Pharmaceuticals 10A, 10B, 10C, 10D
Boeringer Ingelheim, Ltd. 14B, 14C, 14D

Canton Exchange Bank 136
Citizens Bank 15

Darkroom, Inc. 135

Harreld Chevrolet 19

Eli Lilly and Company 132

Mississippi Medical Fraternal and
Educational Society 10
Medical Search Consultants, Inc. 134D

Parke, Davis 8
Premier Printing 15

Riverside Hospital 12
Roche Laboratories second, third and fourth covers, 3
William H. Rorer, Inc. 134B, 134C, 134D

Schering Corporation 6, 7
Smith, Kline and French 14A
Smith Kline Diagnostics 134A
Southern Environmental Products 17

The Upjohn Company 130B, 130C, 130D

U. S. Air Force 18
U. S. Navy 134

Wyeth Laboratories 122A, 122B

Thomas Yates 14

IN CONCLUSION

Most of the patient rights being considered for inclusion in the Mental Health Systems Act of 1979 are already an integral part of good medical practice, the AMA has told chairmen to two congressional committees. The AMA suggested deleting the "Bill of Rights" and legal advocacy provisions because it would encourage an adversary posture, invite extensive litigation, and conflict with established state law and procedures. The AMA also proposed amendments to bring federally assisted mental health programs under the clinical direction of physicians.

A continued sharp decline in propoxyphene misuse has been reported to the House Subcommittee on Health and the Environment. A spokesman for Eli Lilly and Company said there has been a 55% decline since the first quarter of 1977 in drug-related fatalities in which propoxyphene may have played a role. It was noted that there has been a decline of 30% since last spring, when educational efforts were undertaken by Lilly and the FDA. Among the program elements were: revised package literature, 14 million information sheets, prescription vial warning stickers, films.

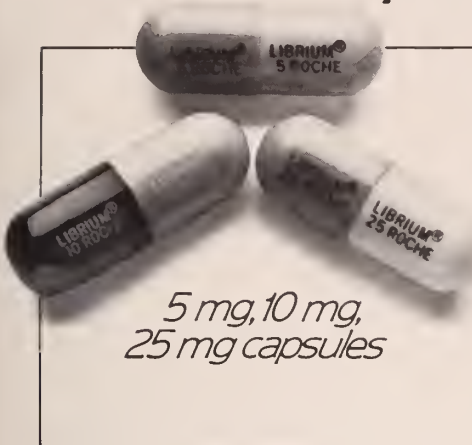
Of the 375,000 active physicians in the U.S., more than 182,000 practice primary care medicine. This is an increase of 29.7% since 1963. The 1979-80 Directory of Residency Training Programs recently published by the AMA shows that 51% of the 64,332 young physicians enrolled in residency training programs are in primary care programs. The biggest increases have been in areas of family practice, internal medicine and pediatrics. Since the first family residency program was approved in 1970, 21,611 physicians have entered family practice.

Members of a new group of compounds that stimulate the body to produce its own interferon have shown antitumor and antiviral activity, Upjohn researchers told the American Association for Cancer Research. The compounds, called 6-phenylpyrimidines, appear to have immunologic activity above and beyond that of interferon itself. Body defense mechanisms other than interferon appear to be related, the researchers said. The compounds are said to be relatively inexpensive compared to the costs of current experimental interferon treatment.

More new ingredients in the government's alphabet soup: Patricia Harris, secretary of the Department of Health and Human Services (HHS) which until last month was known as the Department of Health, Education and Welfare (HEW), has changed the titles of two of the three bureaus of the Health Resources Administration (HRA). The Bureau of Health Facilities, Financing, Compliance and Conversion is now the Bureau of Health Facilities, and the Bureau of Health Manpower is now the Bureau of Health Professionals. "A bureau by any other name..."

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Please see preceding page for a summary of product information

July 1980

JOURNAL of the **MISSISSIPPI** **State Medical Association**



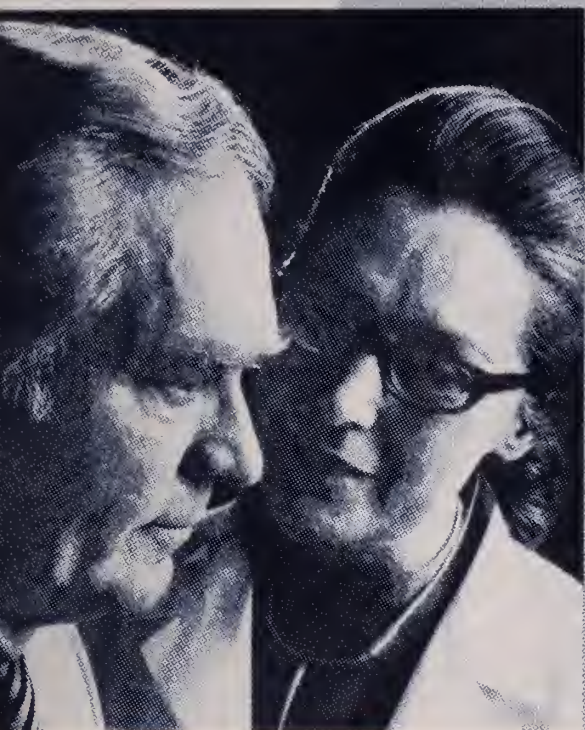
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fulfilled in a wide variety of patients
you see every day.

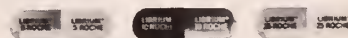




The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium [®] *IV*
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

***synonymous
with relief
of anxiety***

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium[®] 5mg, 10mg, 25mg capsules *chlordiazepoxide HCl/Roche*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults.* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.*. *Geriatric patients.* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

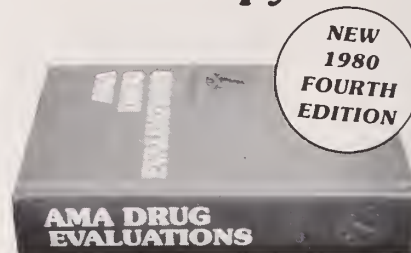
Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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JOURNAL of the **MISSISSIPPI** State Medical Association



July 1980, Volume XXI, Number 7

ORIGINAL PAPERS

- 137** Perinatal Regionalization: It Works for All of Us
JOHN C. MORRISON, M.D. and PHILIP G. RHODES, M.D.
- 143** Radiologic Seminar CCIV: Abdominal Scanning for
Retained Gastric Antrum
JANE A. SANDERS, M.D. and W. MEL FLOWERS, JR., M.D.
- 145** Arachnoid Cysts
EDWARD E. SMITH, M.D.

SPECIAL ARTICLE

- 148** Address of the President
GERALD P. GABLE, M.D.

EDITORIALS

- 151** Bonanza or Boondoggle?
CHARLES L. MATHEWS
- 151** Second Class Medical Care (Reprinted from the *Journal of the Florida Medical Association*)
- 151** Aspiration Cytology in Diagnosis of Breast Cancer
GEORGE H. MARTIN, M.D.

THIS MONTH

- 150** The President Speaking — Government Involvement in
Medicine, PAUL H. MOORE, M.D.
- 160** Practice Management Mailbox — Release of Records

COVER

This month's cover picture is a reproduction of "Motherhood," a watercolor by Frances Melton of Durant. The work was adult purchase prize winner and "best in show" in the University of Mississippi Medical Center Newborn Center's 1977 Art Competition, cosponsored by the March of Dimes. The watercolor is cover art for Christmas and all-occasion note cards on sale through the Department of Public Relations at the University of Mississippi Medical Center. The cards are 35¢ each or \$6.00 for packets of 20. All proceeds benefit the UMC Newborn Fund.

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Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68% *	93% **
Mintezol ¹	35% †	45% ††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.[®]

Please see following page for Summary of Prescribing Information.

**Broad-spectrum coverage
in mixed helminthic infections**

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

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JPI-023



Broad-spectrum coverage in mixed helminthic infections

Vermax[®] TABLETS (mebendazole)

Contraindications VERMAX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMAX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMAX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMAX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMAX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMAX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



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Committed to research...
because so much remains to be done.

UMC Presents 152 M.D. Degrees

A Laurel resident was recognized as top medical school graduate during University of Mississippi Medical Center Commencement ceremonies in Jackson June 1.

Summa cum laude graduate Dr. Richmond Lavern Alexander received the University's Leathers Award as the graduating medical student with the highest academic average. The Mississippi State University alumnus will intern at Baylor University Medical Center in Dallas.

Governor William F. Winter delivered the Commencement address to some 329 UMC graduates and their guests in City Auditorium. Degree recipients included 152 for the M.D.; 77 for the B.S. in nursing; and 15 for the master of nursing degree. Seven students earned the M.S. degree, the M.S. in nursing and the master of combined sciences. Nine students earned the Ph.D. The graduate total also included 18 for the D.M.D.; 16 for the B.S. in medical record administration; seven for the B.S. in medical technology; seven for the B.S. in nurse anesthesiology; and 21 for the B.S. in physical therapy.

School of Medicine honor graduates included Bryan McCraw of Foxworth, Bryan Freeman of Hattiesburg and James Talkington of Jackson, who earned their degrees magna cum laude. Cum laude graduates included Mark Barraza of Natchez, Richard Barry of Jackson, Richard Feibelman of Vicksburg, Geri Grantland of Gautier, Peter Saway of Jackson and Kenneth Verheek of Ocean Springs.

UMC Honors Student, Professors



Peter Saway of Jackson, left, was named senior medical student of the year in School of Medicine awards day ceremonies at the University of Mississippi Medical Center. With him, from left, are Dr. G. William Bates, associate professor of obstetrics and gynecology, clinical professor of the year for 1980; Dr. Norman C. Nelson, UMC vice chancellor; and Dr. Dennis O'Callaghan, UMC professor of microbiology and 1980 preclinical professor of the year.

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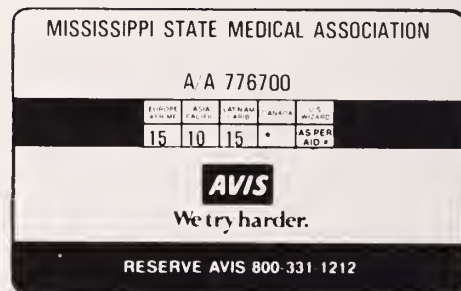
For instance, you'll get 20% off our normal time and mileage rates in the Continental U.S. and District of Columbia.

A 10% discount is offered all published rates in Hawaii.

Your local Avis District Sales Office has the details on how your company can take advantage of these special savings. Simply call them to obtain the necessary discount identification.

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your sales representative will be pleased to establish a plan specially designed to meet your travel and accounting needs.



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DON TERRY

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NEWSLETTER

July 1980

Dear Doctor:

MSMA has entered into an agreement with Avis Rent A Car System, Inc. to provide a significant discount to all association members. The discount consists of 20% off normal time and mileage rates in the U.S. as well as other discounts on foreign rates. To assure receiving the special discounts, MSMA members should always identify themselves at the Avis counter by presenting their Avis charge card, Avis identification card or Avis identification sticker.

If you do not have one of these forms of identification, you may refer at the time of rental to the MSMA Incremental Discount (AID) No. A/A776700. For information on receiving an ID card or programming your current card into the system, please contact Don Terry, Avis District Sales Representative, 2024 Canal St., New Orleans, LA 70112.

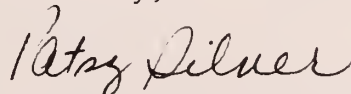
AMA dues will not be raised in 1981. After reviewing the success of the Association's five-year financial plan, the Board of Trustees voted not to seek a dues increase at the annual meeting of the House of Delegates later this month. Since January 1, 1976, AMA dues have been \$250 annually for regular members, \$35 for interns and residents, and \$15 for students.

The investigation of physician participation on open-paneled prepayment plans such as Blue Shield should be ended, the AMA told the Federal Trade Commission. As of June 1979, the AMA pointed out, more than 60% of the plans - representing 77% of total enrollment and 83% of total subscription income - had non-physician majorities on their boards.

A new study says the "belief that millions of people in the U.S. are talked into unnecessary surgery by their doctors apparently is unfounded." Published in the New England Journal of Medicine, the survey of 1,591 patients in the Massachusetts Medicaid program, which mandates second opinions for elective surgery, found that only 11% were told they did not need the operation on second opinion.

NHI will be a reality "in our lifetime," HHS Secretary Patricia Harris said in a commencement speech at Harvard Medical School. "It is a question of when, not whether, of how, not whether, we shall have government-supported universal health insurance in this country," she said. "It may take two months. It may take two years. It may take two decades, but it will come."

Sincerely,



Patsy Silver
Managing Editor

1950s
1960s
1970s
1980s
Progress
with . . .
Thomas Yates & Co.
GROUP INSURANCE ADMINISTRATORS



**Talk is cheap. . .
But here are the Facts!**

1. Within the last three decades. . . we have more than doubled the number of attractively priced Group Insurance Programs available to MSMA Members and their families.
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5. Room and board limits, nurses expense limits and mental illness benefits limits. . . **all** increased. The rate of premium for excess Major Medical Insurance has been **lowered**.
6. Accidental Death and Dismemberment rates reduced 20%. . . lower Overhead Expense Insurance Rates. . . Member and Spouse now may both apply for up to \$100,000 Group Term Life.
7. To the 1980's. . . an all new Cancer Detection Insurance Plan will be made available to all MSMA Members the early part of 1980.

CERTIFICATION
For your protection Thomas Yates & Co. are Members of the American Institute of Professional Association Group Insurance Administrators, Professional Independent Mass-marketing Administrators, Independent Insurance Agents of America, Independent Insurance Agents of Mississippi and Jackson Association of Insurance Agents.
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BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss[®] and Ru-Vert[®]. This advertisement highlights three other products particularly useful for the family.

F-E-P CREME[®]

TWIN-K[®]

SU-TON[®]





**For the Majority of Steroid-Responsive
Dermatoses* Seen in Family Practice**

F-E-P CREME®

(Iodochlorhydroxyquin — Pramoxine HCl — Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.



*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

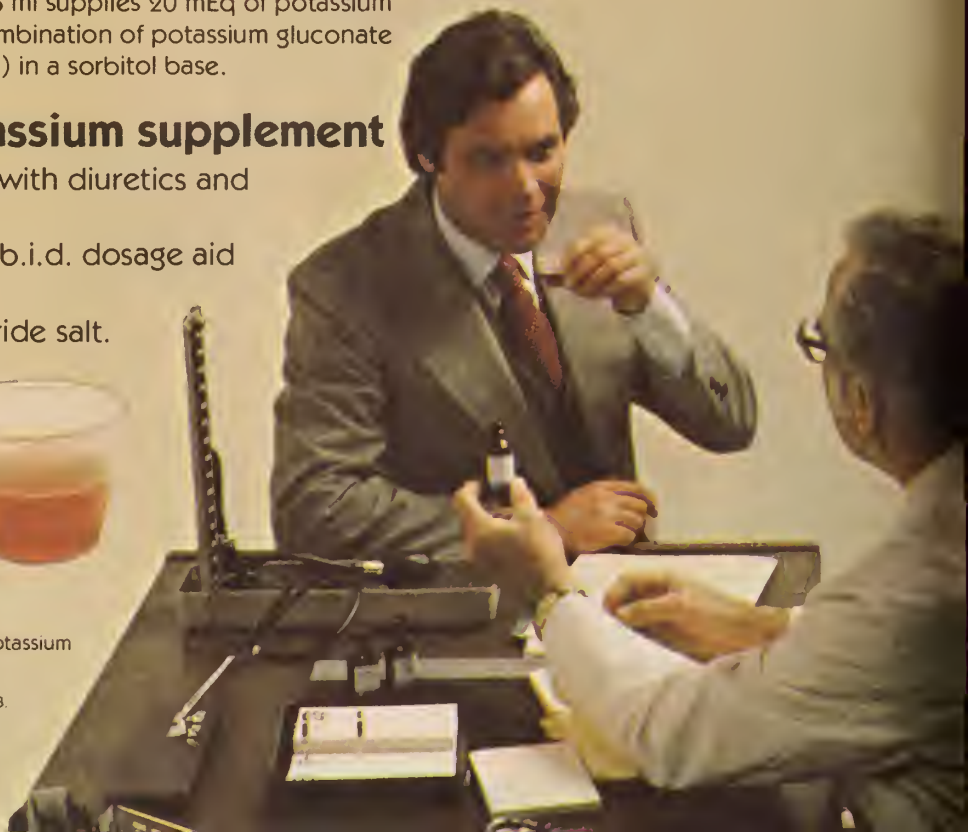
"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."¹



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

¹ Beeson-McDermott, Textbook of Medicine, 15th Ed 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.



For the Geriatric Patient

SU-TON[®]

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol.	30 mg
Niacin.	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.

Please send me patient starter samples of:

☐ F-E-P CREME[®]

☐ TWIN-K[®]

☐ SU-TON[®]

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin.....	3.0%
Pramoxine Hydrochloride.....	0.5%
Hydrocortisone.....	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.

2. F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes NDC 0524-0026-51	½ ounce (15 gm) tubes NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice,

two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) or TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol.....	30 mg
Niacin.....	50 mg
Vitamin B-1.....	10 mg
Vitamin B-2.....	5 mg
Vitamin B-6.....	1 mg
Iron B-12.....	3 mcg
Choline.....	100 mg
Inositol.....	50 mg
Manganese (as Manganese Sulfate).....	2 mg
Magnesium (as Magnesium Sulfate).....	1 mg
Zinc (as Zinc Sulfate).....	22 mg
Iron (as Ferric Pyrophosphate, Soluble).....	18%
Alcohol.....	

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED: Bottles of 473 ml (16 fl oz) NDC 0524-0015-16

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001

5-80

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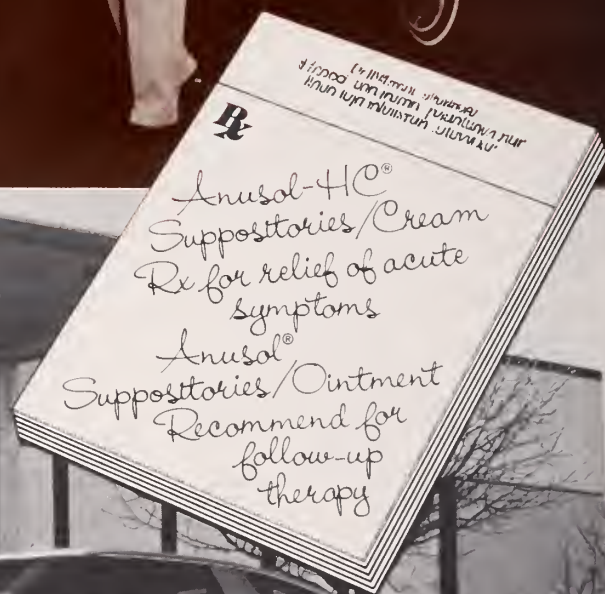
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#1 prescribed hemorrhoidal product

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ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%, also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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00022 PD-JA-0234-I-P

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Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA

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GAO Report Says Drug Lag Exists in U.S.

The General Accounting Office (GAO) has reported that there is a "drug lag" in the United States.

Stating that the Food and Drug Administration may be denying beneficial medication to ill persons, the report indicates that a number of important drugs in the study had been approved overseas more rapidly than in the U.S.

The average approval time for a drug in the U.S. is 20 months compared with Great Britain, five months; Switzerland, 12 months; Canada, 16 months; and Norway, 17 months. Only Sweden, with a 28-month average, exceeded the U.S.

UMC Faculty Appointments Are Announced

Two assistant professors and an instructor have joined the School of Medicine faculty at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their July 1 appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Clinton M. Cavett was named assistant professor of surgery (pediatric) and an instructor in pediatrics. Dr. Thomas S. Moore is new assistant professor of radiology. Dr. Reynaldo Rodriquez was named an instructor in anesthesiology.

Dr. Cavett, an instructor in surgery at George Washington University School of Medicine since 1978, attended Millsaps College and earned the M.D. degree at University Medical Center in 1973. He interned at Parkland Memorial Hospital in Dallas and took residency training at UMC and at Children's Hospital, National Medical Center in Washington.

Dr. Moore, an assistant professor of radiology at the University of Virginia School of Medicine since 1979, earned the B.A. degree at the University of Virginia and the M.D. degree at Cornell University Medical College. He interned at Georgetown University Hospital and took residency training there and at the University of Virginia Medical Center. He was a fellow in special procedure radiology at Virginia Medical Center from 1978-1979.

Dr. Rodriquez earned the B.S. and M.S. degrees at Texas A & I University in Kingsville. He earned the M.D. degree at Baylor University School of Medicine, and has been a resident at UMC since 1977.

Tenuate®

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in the evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in the morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.
Licensor of Merrell®

References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M. T., O'Dillon (Oillon), R. H. and Leyland, H. M.: A comprehensive review of diethylpropion hydrochloride. In: *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

**Overweight may not always be simple...
complications can develop*.
Complicated or not...**

Tenuate® Dospan®^{IV} **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell



For prescribing information see opposite page

In G.I. therapy



Adjunctive
Librax[®]

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

**for adjunctive therapy of duodenal ulcer*
and irritable bowel syndrome***

Librax[®]

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addic-

tion-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

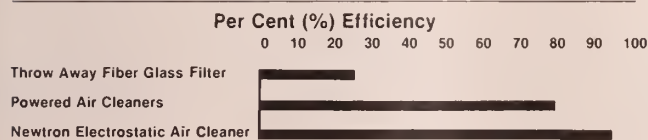
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Roche Products, Inc.
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Doctor, your patients will be asking about the Newtron® Electrostatic Air Cleaner.

And with good reason. The Newtron® electrostatic air cleaner is a revolutionary new device that allows allergy patients to breathe clean air in their homes and offices — at a much lower cost than has ever been possible before.

In fact, the Newtron® is the only reasonable answer to the problems caused by pollen, dust, smoke, and other air pollutants. It requires no electricity, never needs to be replaced, requires no maintenance other than a monthly rinsing with tap water, and comes in standard filter sizes to simply replace the existing throw-away filter in heating and air conditioning systems. Even more importantly, it far out-performs all other cleaners, including electrically powered models costing more than three times as much.



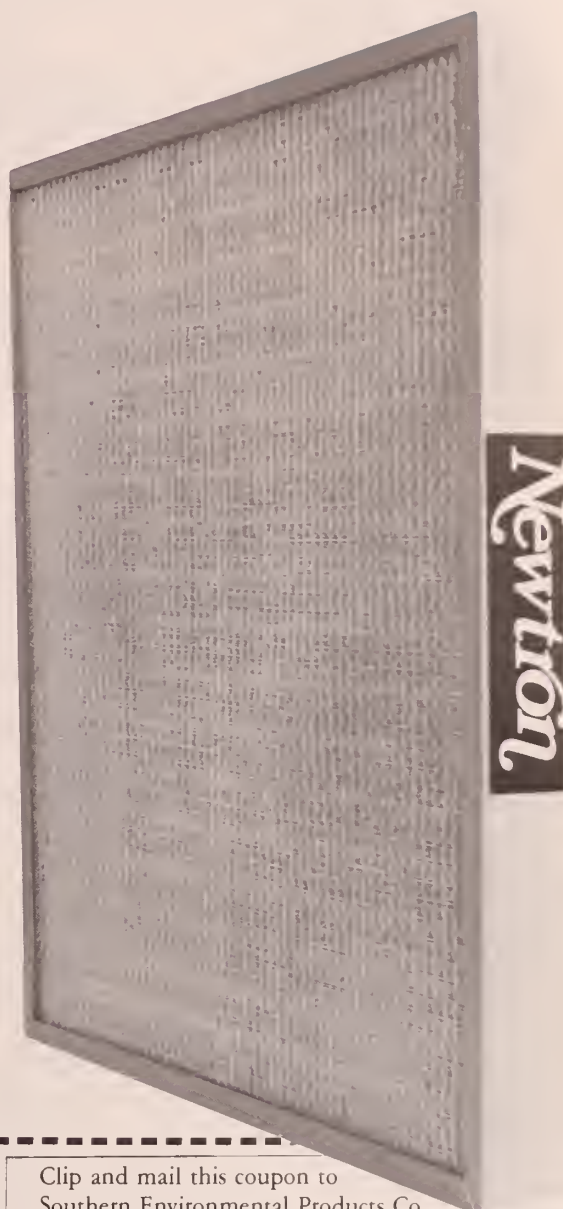
In the past, high costs and complicated installation have put truly clean air out of the reach of most allergy patients. Now that the Newtron® is available — and has been proven effective in hospitals, businesses, private homes, and apartments — your patients will be asking for your approval or opinion.

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Riverside Hospital is unique in Mississippi.

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Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

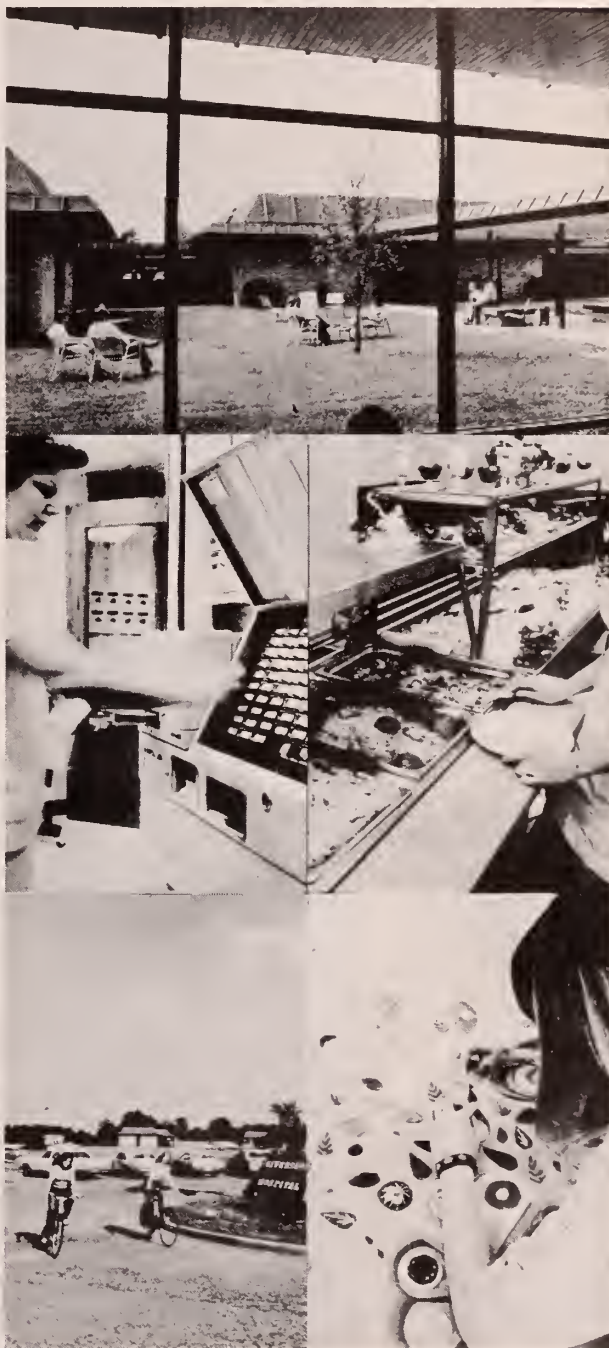
The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.

Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030



An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

Ceclor®

cefactor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefactor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor® (cefactor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630

000482

ORIGINAL PAPERS

Perinatal Regionalization: It Works for All of Us

JOHN C. MORRISON, M.D. and PHILIP G. RHODES, M.D.

Jackson, Mississippi

MATERNAL MORTALITY associated with pregnancy has continued to decline since reproductive statistics began to be accurately tabulated in the early part of this century. With such scientific advances as antibiotics, safer blood products and contraception, maternal mortality fell rapidly (see Table I).

The reduction in perinatal mortality, defined as fetal and neonatal deaths, was noted during the early 1960's with the advent of specialized neonatal care. Encouraged by the results of their neonatal intensive care units, several states organized regional systems to transport infants in need of specialized care from rural areas to specialized units. Supported by the National Foundation-March of Dimes, private foundations such as Robert Wood Johnson, and innovative state legislatures, this system of regionalization produced a striking reduction in perinatal mortality in such areas as Arizona, Wisconsin, Iowa and Massachusetts.

Stimulated by the demonstration of what was possible through regionalization, several large health care groups including the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the National Foundation-March of Dimes, designated as a top priority the improvement of perinatal health care. These organizations and others, including the federal government, endorsed the system of perinatal regionalization as the primary

method for reducing the risk to the mother/fetus/newborn.

As a result of a coalition between the large foundations and governmental bodies and nationwide specialty organizations, the document *Toward Improving the Outcome of Pregnancy* was printed in the mid-1970's. This document describes how the system of regionalization works. At about the same time, the Mississippi State Medical Association appointed a State Perinatal Advisory Committee (Ad Hoc Committee on High Risk Maternal and Newborn Care) to formulate guidelines for regionalization of our state. In January 1979, these guidelines were approved by the State Medical Association and the Health Systems Agency.

TABLE I
COMPARATIVE MATERNAL OUTCOME STATISTICS

Maternal Mortality Rate*	
<i>United States</i>	
1920	957.8
1940	596.2
1950	284.6
1970	67.8
1977	13.6
<i>Mississippi</i>	
1940	622.5
1950	256.1
1960	99.6
1970	70.6
1975	13.8
1976	18.6
1977	13.0

*Deaths/100,000 live births.

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REGIONALIZATION / Morrison

Many states have now adopted the system of regionalization, most of them supported and funded by public sources (federal and state government). Other areas, however, have not initiated perinatal regionalization due to lack of financial support, political differences, or geographic difficulties. Mississippi is one of those areas. However, it appears at this time that Mississippi has many groups who have agreed to work together in order to solve the problem of the state's high perinatal mortality. Hopefully, this will be the beginning of perinatal regionalization for our state.

According to present statistics, there are over 400,000 women of childbearing age (15-44 years) in Mississippi. These women gave birth to between 40,000 and 50,000 infants per year over the past decade. Unfortunately, each year Mississippi has ranked last in reproductive statistics, having the greatest number of infant and neonatal deaths each year (see Table II). Moreover, the number of fetal deaths and abortions, although not accurately recorded, appears to be one of the highest in the country. Also, the rate of immature, premature and low-birth-weight infants among these births, as well as those born to teenage, indigent or medically complicated parturients, is near the highest in the nation. Finally, as a compounding factor, three times the number of infants who die, apparently survive with profound mental, physical or subjective damage

which impairs them permanently. Mississippi again leads the nation in many of the morbidity categories.

Scientific advancements in Mississippi obstetrics have reduced maternal mortality (as well as morbidity) to at least parity with most of the states in the union as shown in Table I. Through new technology available in neonatal care at the medical center in Jackson as well as in some of the perinatal care centers distributed throughout the state, significant improvement in infant survival rates and in the quality of life for these offspring is available. The state has made considerable progress in reducing infant mortality, decreasing from 41.5 deaths per 1,000 live births in 1965 to 18.3 deaths per 1,000 live births in 1977.

However, as previously stated, Mississippi continues to lead the nation in this category as well as in most of the other neonatal morbidity statistics (see Table II). One of the contributing factors in this problem is that 48% of the children in this state are born to parents existing below the 125% poverty level. These indigent patients, with their attendant socioeconomic deprivations, often have limited access to medical care. Even though the State Health Department accepts these patients in most areas of the state for ambulatory prenatal care, there is no organized commitment on a statewide level for delivery of intrapartum care. The fact that Mississippi is an agrarian state with a single large metropolitan area (greater than 200,000) contributes to this situation.

TABLE II
COMPARATIVE INFANT, FETAL AND NEONATAL MORTALITY RATES 1965-1977

	Mississippi	United States	Mississippi Rank	Best State
1977, live births	45,532	3,326,632	45th	—
1965, infant mortality rate‡	41.5	24.7	50th	18.8 (Utah)
1975, infant mortality rate	22.5	16.1	50th	12.9 (Hawaii)
1976, infant mortality rate	21.6	15.2	50th	10.8 (Hawaii)
1977, infant mortality rate	18.3	14.1	50th	9.5 (Maine)
1977, immature live births	3,991	234,884	49th	—
1977, percentage low birth weight	8.8	7.1	49th	5.1
1977, percent births to women without care first trimester*	28.3	24.9	36th†	12.1
1977, percent births to women under twenty	25.8	17.2	50th	11.4
1977, percent births to women without high school completion	41.5	26.2	45th†	11.6

* 1977, percent births to women who were known to have had prenatal care and known to have started later than the first trimester.

† No data available for some states.

‡ Deaths/1000 live births.

Sources: Office of Public Statistics, Mississippi State Board of Health. "Selected Data on Perinatal Health by State, 1977," National Foundation/ March of Dimes, DHEW Perinatal Statistics Survey, 1978.

In summary, it should be evident that the state of Mississippi has a large number of patients at risk, both socioeconomically and medically. These facts plus the lack of proper utilization and accessibility of health care resources and quality of care for all patients have led to the lag in improvement of perinatal health care statistics.

Although there are many indigent patients who have problem pregnancies in this state, poor reproductive outcome is not limited to this group alone. Indeed, because of complacency and lack of knowledge about the availability of proper care, patients who are financially responsible also often receive less adequate care. However, other states with equally high perinatal mortality rates have had success in attacking this problem through statewide regionalization of perinatal health care services. It is clear that we need to reemphasize the importance of perinatal regionalization.

Definition

Regionalization may be defined as the development, within a geographic area, of a coordinated system of maternal and perinatal health care in which all parties (hospitals, physicians, health department, employees, paramedical personnel and consumers) work to improve the care of all pregnant women and their infants by maximal utilization of personnel and facilities at the most reasonable cost. Thus, this system has a common goal to provide the optimal maternal, fetal and neonatal care appropriate to the needs of each patient and available to every patient. This care involves both outpatient (ambulatory) as well as inpatient (hospital) care. It is symbolized by the concept that patients who have few or no medical problems will deliver in their local area. However, after risk assessment the patient at moderate risk may be referred to a perinatal care center (Level II), and the extremely complicated patient may be referred to the tertiary (Level III) unit at the medical center.

Regionalization of perinatal health care services must be differentiated from centralization. Centralization implies sending most patients to a centralized location for care. Regionalization, on the other hand, embodies the concept of preventive medicine by risk identification and referral of only those patients at high risk to levels of higher care. In addition, as providers at a local level become more adept (via education) at complicated patient care, greater numbers of patients can be managed in the local area, although the opportunity will still be present for referral to a secondary or a tertiary center those at extremely high risk or those needing sophisticated

equipment for diagnosis and treatment.

Therefore, regionalization affords any and all patients within the state access to the most sophisticated and specialized services, but the need for transfer of these patients will be reduced in a logarithmic fashion as: (1) the number of complicated cases are reduced by preventive perinatal risk assessment and (2) continuing outreach education of the local health care providers allows them to assume responsibility for increasing numbers of patients at the primary level. Thus regionalization through education and referral is a means of instilling a preventive rather than a crisis type of medicine.

Regionalization Guidelines

The guidelines set forth by the State Perinatal Committee are very close to those recorded in the document *Toward Improving the Outcome of Pregnancy* which has been used successfully as a model for perinatal regionalization in many other states. It proposes that three levels of care be set forth.

Level I, or community hospitals, would provide intense perinatal risk assessment as well as delivery of normal intrapartum care and well baby care. The perinatal care centers (Level II units) also perform perinatal risk assessment and normal deliveries, but also may receive from Level I units patients identified as complicated maternal or neonatal cases. The tertiary center (Level III unit) has been designated as the Medical Center in Jackson. This unit is not only responsible for perinatal risk assessment and the delivery of normal and complicated care, but also remains ready to care for those cases requiring intense maternal/newborn diagnostic or therapeutic techniques. Moreover, the Level III unit is responsible for research and education of the local health care providers throughout the state as well as the training of personnel such as physicians, nurses, technicians, and ancillary persons who will in the future serve the outlying areas. Finally, the center is responsible for data assimilation and analysis to be used in an educational function.

At the present time, the levels of care are clearly designated in the guidelines proposed by the State Perinatal Committee and each hospital or unit is encouraged to assess their own needs and resources to determine at which level they would like to render care. It is important, however, that these guidelines be initiated in the near future because the federal government, due to cost containment programs already in force in some states, is moving toward enforcement of federal guidelines in the future. Obviously, a federal program would be rigid and have little latitude for special situations and would

REGIONALIZATION / Morrison

probably involve attempted closure of some units. For this reason also it is important to set up the system of perinatal regionalization based on needs and desires of each area in a defensible fashion prior to government intervention.

Assessment of Health Care Needs and Resources

Prior to implementation of regionalization, it is necessary to document the health care needs and resources in each area. First, a sample number of hospitals evenly distributed around the state (involving both small and large units) must be visited in order to assess the medical needs. These areas must also be polled from the standpoint of facilities, equipment and personnel. Finally, and most importantly, educational needs must be documented.

Next, the available resources must be detailed. The facilities and equipment currently in use, as well as those projected, must be documented. The number and types of physicians and nurses and their levels of expertise should be elucidated. Once this task is performed, a more accurate idea of the proper method of implementation can evolve.

There are several components which have significant interplay in any workable system of regionalization. First, the medical community in each local area has both an ambulatory as well as a hospital role. In their private offices, these physicians and nurses see pregnant patients on an ambulatory basis and also deliver intrapartum care to those patients seen prenatally by health department offices throughout the state. These health care providers in the local area, with their facilities, equipment and ancillary personnel, must play a great role in shaping the decisions and mechanisms by which regionalization is accomplished in their area. Obviously, the referral patterns from the small community hospitals and the physician's offices must exist uniformly on a statewide basis. Finally, transportation and communication between the local areas and the more specialized areas must be available.

The Mississippi State Board of Health is responsible for delivering antepartum and postpartum care as well as some infant assessment to approximately 50% of the pregnant patients in this state. At the present time, due to limitations in funding, many of the health department's services in primary care for the pregnant woman and her baby are not uniformly available throughout the state. A few projects aimed at very high risk areas have demonstrated positive results; however, such projects are usually fragmented and are usually funded with non-continuing

sources of revenue. This lack of uniformity, the extreme high risk population, and inadequate funding have limited the health department's ability to impact completely on the problem of perinatal wastage. They remain, however, one of the most essential portions of regionalization in that they have an opportunity to interact with the large number of high risk patients as well as deliver subsequent preventive health care. Moreover, the possibility of followup provides an access to continued improvement in health care for the offspring as well as the non-pregnant woman. Hopefully, this could lead to better reproductive outcome for future pregnancies.

As stated previously, the tertiary center of University Medical Center is responsible for rendering patient care to normal and high risk parturients, for research in new and sophisticated areas of perinatal medicine, for data assimilation and analysis concerning reproductive outcome, and for education of both future and existing health care providers. Unfortunately, at the present time, these functions are taking place in an area severely limited by overcrowding. Designed for 2,200 deliveries per year, the perinatal unit at the medical center accommodated nearly twice that number in 1979, and is projected to be serving over 5,000 in the near future. This situation critically affects quality patient care, research and, most importantly, medical education. New and expanded perinatal facilities are essential for the medical center to fulfill its role in perinatal regionalization and health care provision. Based on experience from other states, as well as exhaustive research for alternatives in the metropolitan area, this need will best be filled by the new perinatal center under consideration by the legislature.

Finally, the recipient of this care (the consumer) is a most important area. Intensive consumer education in nutrition, medical risk, contraception and general preventive health care is essential for regionalization to reach its goal. Obviously, the best health care delivery method available can have no impact if the patients do not avail themselves of the system. Therefore, an intensive effort must be made to ensure that each pregnant patient understands the importance of antepartum, intrapartum, postpartum and interpregnancy care for her and her family.

It appears, therefore, that in a combined effort by the State Board of Health, community health care providers, the medical center and the consumer, regionalization can take place and achieve its goal. Only by minimizing political, social, and individual differences between these groups will we be able to drastically reduce the perinatal mortality/morbidity rates in this state.

It is obvious from previous comments that regionalization involves three basic parts: communication, data assimilation and analysis, and education.

Communication

Communication must be a two-way interchange of information and ideas. The first area, verbal communication, is in place at this time. A 24-hour, 7-day per week perinatal hotline to both the neonatal intensive care unit (987-3434 collect) and obstetric intensive care unit (800-962-2213) is functioning. This allows health care providers from all over the state to speak at any time with attending intensive care staff regarding perinatal problems. Written communication has also been established. When a patient is referred to the tertiary center, a letter is written to the health care provider in the local area detailing the patient's progress. Moreover, if the patient is hospitalized, a copy of her records and a letter regarding outcome are returned to the local physician.

A vital part of this written communication is the common perinatal risk assessment record. This will be mentioned under the data analysis section, but deserves special emphasis here. If all health care providers in Mississippi use a risk assessment record, not only can preventive perinatal health care be offered, but also the circle of written information from the rural area to the Level II or Level III center and return can be completed. Finally, through mass communications using advocacy groups and various forms of visual, verbal and written methodology, one can reach the consumers in every local area. In this phase, consumer education, particularly as it involves convincing women to enter the health care system early, will be of vital importance.

Data Assimilation and Analysis

The data accumulation section of this project is an integral portion of regionalization and is tied to communication. It is essential that a risk assessment format be used. At the present time, the Hollister record is used in the Central Health Department district, by the tertiary center and several private groups over the state. This record allows patients at risk to be identified in a preventive fashion and the complication resolved before fetal or maternal deterioration occurs. This form is easily computerized. If most of the health care providers in the state use this form for obstetric and neonatal patients, the data can be easily assimilated and analyzed. This will be advantageous for several reasons. The data can be entered in the computer, and each health care provider can be "on line." This means that the person in the rural area will have access to data on the patient

in the Level III center and vice versa. This allows up-to-the-minute reporting of any problems and assessment of progress in each patient. Another reason why this system is important relates to education. With the statistics available on a quarterly or yearly basis, it is possible to compare data in an educational sense. In this very confidential fashion, each health care provider can assess not only his patients but also improvements in his practice as it relates to using specific methods of risk assessment or educational patient care protocols.

Education

Education, the most important portion of regionalization, comes in several forms. First is education for the health care providers from each local area of the state. This education can be performed by didactic courses in the central area (medical center), in the perinatal care centers or in the community hospitals. These can be offered as practical courses during which a local health care provider comes to the center for one to three weeks of training, or by in-depth didactic programs developed within the center but given in the local area. Second, the development of practical patient care protocols can be engendered in the tertiary center and distributed throughout the state as requested by the providers. The use of these protocols and their effect on patient care can be assessed by data analysis performed from the common perinatal record. All of these educational techniques would upgrade not only the skills but also the knowledge of local health care professionals in dealing with the pregnant woman and her child, even in complicated cases. The educational opportunities would also be applicable in antepartum/postpartum patients to providers in the local health department offices, who care for approximately 48% of the patients during these periods.

There must be close interdigitation in the educational format directed toward the health department and local hospitals as a unit rather than separately in each area. This should increase the communication between the private physician and local health department offices. Finally, programs of education related to the training of resident physicians, nurses and other health care professionals in the tertiary center would be modified by input from the local level as to what type and number of providers are needed in the state in the future. The direction of the tertiary center's program could then be molded to fit those needs.

Commitment to a System

For the system of regionalization to be effective in

its goal to reduce perinatal mortality, there must be a commitment on the part of all persons involved in the delivery of perinatal health care. First, there must be a commitment on the part of the educational system in the tertiary area (the departments of obstetrics-gynecology and pediatrics and the public health department) to work together in complying with requests from the practitioners in the local areas. Secondly, other groups such as the departments of family practice and anesthesia, as well as the school of nurse-midwifery and school of nursing, must also commit to such a system in the tertiary center so that a firm foundation can be laid. Next, the commitment of local physicians to join such a system in their hospitals, offices and area health departments must be made. This is a commitment not only to the system of regionalization, but also to health care of pregnant women and their babies in general. It is no longer enough to care for only those with financial means; a commitment to all pregnant women and their offspring must be made.

There also must be a resolution of support on the part of the state for perinatal health care. At the present time, much more money per year is spent in crisis or remedial areas of medicine such as renal transplants, cardiovascular disease and crippled children's services than on perinatal health care. It seems that these funds might better be expended in preventive medicine aimed at the most rewarding group of subjects, the pregnant woman and her newly born infant. Since Mississippi leads the nation in the per capita amount expended on institutionalized infants, it appears much more cost effective to prevent an institutionalized infant than to care for one throughout its life.

Therefore, the legislature should make a commitment to all perinatal health care recipients since, in the long run, this will be the most cost effective method. We have seen what "seed" money can do in various demonstration perinatal projects; however, this advantage must be extended to the entire state if we are to change mortality statistics.

Finally, there must be a commitment by the recipient of perinatal health care to the *responsibility* of being pregnant. No matter how good the methodology is, it will fail if the recipients do not partake of the system. Therefore, it is a must that all patients at risk be identified and entered into the perinatal health

care system very early in their pregnancies.

Summary

The ultimate success of regionalization obviously depends on many factors, some beyond our reach at this time. However, surprisingly many of them are already in place and may be useable through cooperative management. The need for such a program has been graphically demonstrated. The drastic reduction in perinatal mortality statistics in other states using regionalization serves as a demonstration of what can be done by a system of preventive perinatal health care. There has been agreement between the principal components of perinatal health care delivery (the University Medical Center, the State Board of Health, community physicians/hospitals, and consumer groups) that regionalization is the method by which we should seek to solve the problem of reproductive wastage.

What remains to be done is: (1) to develop and implement a system of outreach education for providers and consumers of health care within the state; (2) continuous participation and involvement of representatives of all groups interested in the planning and implementation process of perinatal health; (3) identification of sources of funding to insure a system of quality health care for all pregnant women and their offspring; and (4) moral and financial support by each and every citizen of Mississippi as evidenced in a commitment by the legislature to support perinatal health care regionalization. Only in these ways will we achieve our goal of reducing perinatal health care problems.

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Radiologic Seminar CCIV: Abdominal Scanning for Retained Gastric Antrum

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IN PATIENTS WITH RECURRENT peptic ulcer disease following gastric resection, it is necessary to exclude the existence of both Zollinger-Ellison syndrome and retained gastric antrum. Both conditions present with recurrent, persistent stomal ulceration despite partial gastrectomy and truncal vagotomy, and both exhibit a high gastric basal acid output.

Excluding retained gastric antrum from the differential diagnosis of recurrent ulcer disease in post-gastrectomy patients may be accomplished by a simple abdominal scan following intravenous injection of ^{99m}Tc -pertechnetate. If a negative abdominal scan is obtained, further evaluation can then be directed towards evaluation for Zollinger-Ellison syndrome.

In Zollinger-Ellison syndrome an islet-cell tumor arising in the pancreas produces large amounts of gastrin leading to gastric hypersecretion. Retained gastric antrum occurs in patients who have undergone Billroth II type gastrectomy. An area of gastric antral mucosa is accidentally retained in the duodenal stump. These gastrin cells are no longer inhibited by gastric activity and release much more gastrin than normal. The result is hyperchlorhydria and recurrent stomal ulcers.

One technique used to differentiate between Zollinger-Ellison syndrome and retained gastric antrum is the secretin test. Gastrin secreted by a pancreatic tumor responds differently to secretin stimulation than does gastrin of antral origin. Intravenous secretin injection causes a marked fall in serum gastrin and gastric acid output in patients with retained gastric antrum. Patients with Zollinger-Ellison syndrome exhibit a rise in serum gastrin. These gastrin levels are usually determined by radioimmunoassay. This test, while reliable, is laborious and time-

consuming, and may not be readily available in smaller institutions.

Abdominal scanning with ^{99m}Tc -pertechnetate can be performed in any nuclear medicine department having a gamma camera. It has proven to be a simple, reliable method of demonstrating retained gastric antrum.

The concept of abdominal scanning for ectopic gastric mucosa is not new. It has been used for many years to search for Meckel's diverticulum and Barrett's esophagus. In both of these conditions any ectopically located gastric mucosa will concentrate pertechnetate and be visualized upon scanning. Gastric mucosa behaves the same in concentrating the isotope whether it is located in the stomach or ectopically.

The rationale for this approach is that the TcO_4^- (pertechnetate) ion has a biological behavior similar to those of halogen group of the periodic table (Cl^- , I^- , Br^-) and thus is selectively concentrated in certain organs including the stomach. There is still controversy as to the cellular site of pertechnetate secretion, but current animal research suggests that it is predominantly concentrated in the mucous-secreting cells of the stomach, and less by the parietal and chief cells. For this reason the antral mucosa is able to concentrate pertechnetate despite its lack of parietal cells.

The patient requires no advance preparation. A dose of 10 mCi ^{99m}Tc -pertechnetate is injected intravenously, and images are obtained, using the gamma camera, at 10 minute intervals up to 60 minutes. Multiple images taken over this time period should exclude any false positive images that might arise from accumulation of gastric secretions in the tip of the duodenal stump. Retained gastric antrum presents as an area of intense activity in the midepigastric area or right upper quadrant which is persistent over multiple images (See Figure 1). Recent

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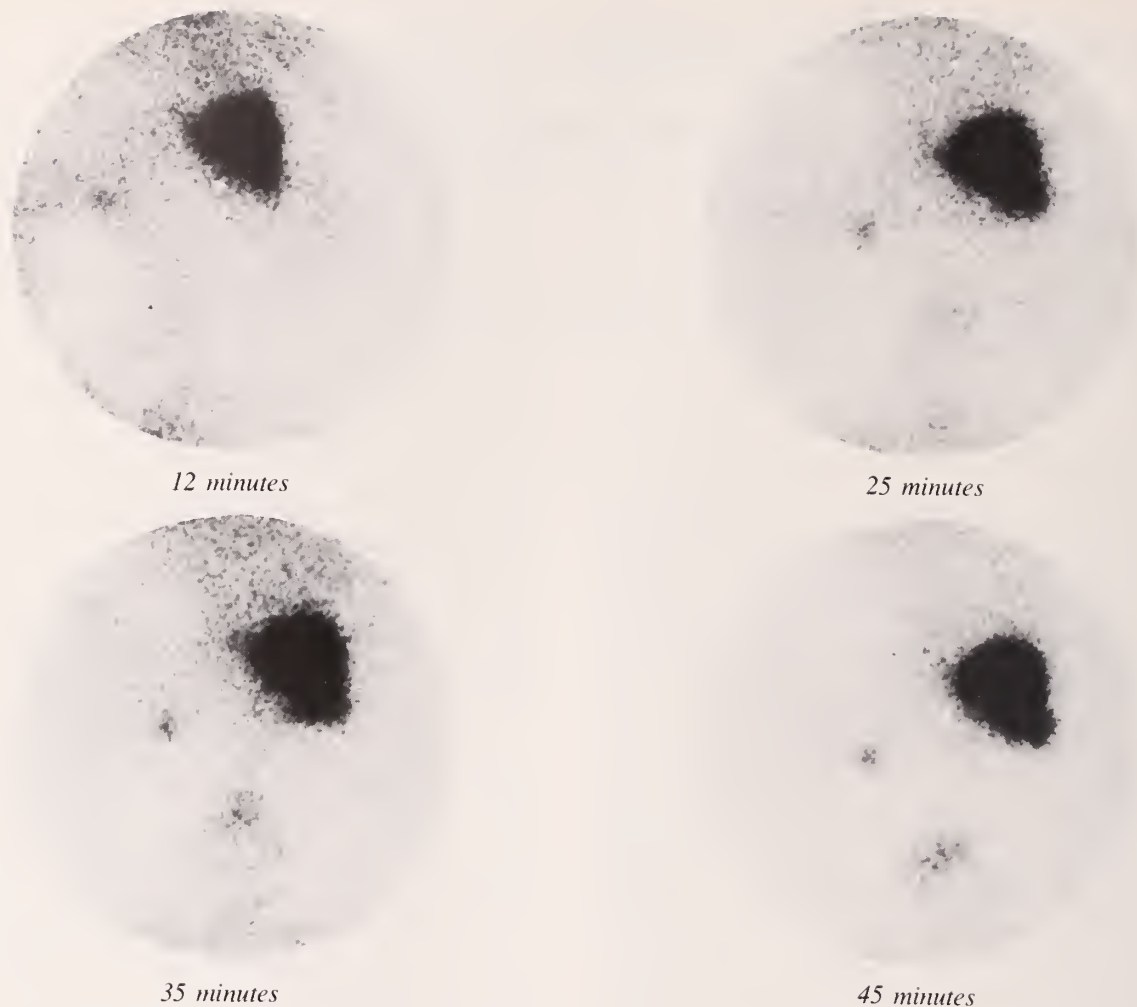


Figure 1. Abdominal scan of a 61-year-old man with proven recurrent peptic ulcer disease following Billroth II gastrectomy. Retained gastric antrum is demonstrated as a small area of uptake in the right side of the abdomen. The activity accumulating in the lower abdomen is normal gastric secretion passing into the small bowel.

animal research suggests that an area of retained antrum as small as 1 cm can be adequately visualized utilizing this method. No false negative examination has ever been reported.

Summary

A simple abdominal scan following intravenous injection of ^{99m}Tc -pertechnetate can exclude retained gastric antrum from the differential diagnosis of recurrent ulcer disease in post-gastrectomy patients. If the scan is negative, further evaluation can be directed toward evaluation for Zollinger-Ellison syndrome. ★★★

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Arachnoid Cysts

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CYSTIC FORMATIONS in the cranial or spinal arachnoid membranes, designated variously as arachnoid cysts, meningeal cysts, or leptomeningeal cysts, are relatively infrequent and usually asymptomatic; but they can on occasion produce symptoms of a space-occupying lesion or present as a cause of hydrocephalus. The widespread use of computer-assisted tomography (CT scans) greatly increases the likelihood of their incidental discovery even when asymptomatic. An awareness of their possible occurrence, usual locations, and other features is desirable to avoid mistaking the unexpected lucency or cerebral asymmetry of a benign arachnoid cyst for an intracranial neoplasm.

The accompanying illustrations are from a 66-year-old man with a suspected brain metastasis from a bronchogenic squamous cell carcinoma. In a CT scan made 18 months before death, a density consistent with a metastasis was found in the left parietal lobe and is not shown in the scan "cut" reproduced here. An incidental finding, however, was a sharply-defined lucency at the tip of the left temporal lobe (see Figure 1). Following the patient's death from pulmonary complications of his tumor, examination of the brain disclosed an arachnoid cyst in the left anterior Sylvian fissure (see Figure 2). By comparing both sides of the brain, it can be seen that the cyst had produced distortion of the left temporal lobe. The patient's history gives no evidence that he ever had symptoms from this lesion.

The mechanism of formation of arachnoid cysts is poorly understood. In much of the neurosurgical literature they are regarded as being of infectious or traumatic origin.¹ In many, if not most, cases, however, no distinct history of trauma or meningeal infection is elicited, and the histologic examination of a cyst such as the one illustrated will show its wall to be composed simply of a thin layer of meningotheelial cells and a small amount of collagenous connective tissue. Changes which might be expected to follow infection or trauma, such as inflammation, fibrosis, blood pigment, and calcifications, are no-

tably lacking. Cyst contents usually resemble cerebrospinal fluid. Although there can be no doubt that cystic arachnoidal loculations secondary to infection, trauma, or hemorrhage can occur — the cicatricial cysts of adhesive spinal arachnoiditis, for example — most arachnoid cysts may be regarded as

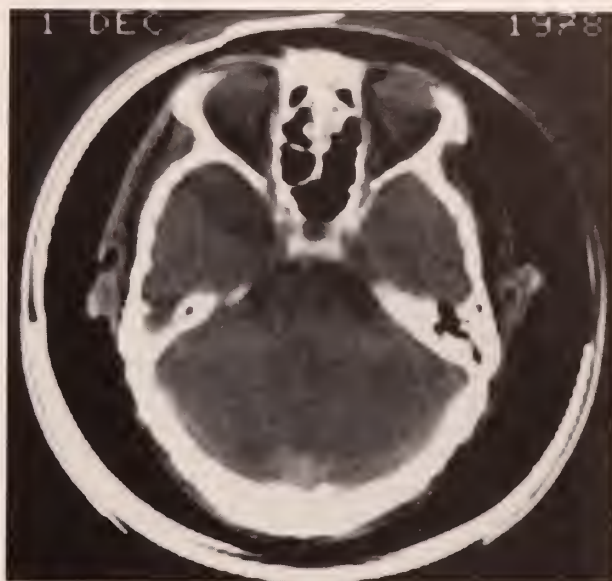


Figure 1. The CT scan shows lucency in the anterior left middle fossa.



Figure 2. Picture of the brain shows an arachnoid cyst in the area corresponding to the lesion on the CT scan. The arrows outline the margins of the (ruptured) cyst.

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ARACHNOID CYSTS / Smith

"primary" cysts, and other explanations for their development must be sought. A frequently cited hypothesis is that they result from a developmental defect permitting an abnormal passage of cerebrospinal fluid into the mesenchymal tissue which forms the arachnoid membrane during embryonal development.²

This concept is particularly applicable to arachnoid cysts occurring in newborn infants,³ but is less satisfactory for cysts in adults. The authors of a recent electron microscopic study⁴ of arachnoid cysts reject the developmental defect hypothesis in showing that the cells which line an arachnoid cyst resemble the ultrastructurally distinctive cells of the outer arachnoid membrane (the subdural neurothelium). These cells have ultrastructural features suggesting a secretory capacity, and hence, the authors maintain, have an intrinsic potential for cyst formation throughout life.

Incidence

The incidence of arachnoid cysts is unknown; of space-occupying lesions an estimate of about 1% appears reasonable.⁵ Autopsy surveys are generally unreliable in determining the incidence because the thin-walled cysts usually rupture during brain removal and are easily overlooked. Possibly, a review of a series of CT scans might provide a reasonably accurate estimate of their frequency. Arachnoid cysts occur at any age, but symptomatic cysts are most often reported in infancy or childhood and in adult middle age.⁵

Arachnoid cysts may occur anywhere in the cranial or spinal arachnoid membranes, and even, very rarely, in intradural or extradural locations. Preferred sites are the convexities of the brain, the interhemispheric fissure, the Sylvian fissures, the supra- or paracollicular regions, the posterior fossa, and the spinal canal. They are rare at the base of the brain. In sites such as a Sylvian fissure they are unusually unilateral. Typical locations in the posterior fossa are the midline retrocerebellar region and the cerebellopontine angles. Spinal cysts usually occur as elongated sacs overlying the dorsum of the spinal cord, typically in the cervical or thoracic regions. It is also in the spinal canal that intradural or epidural arachnoid cysts may be found. Some of these may originate as arachnoid diverticuli.

As in the case illustrated, cranial arachnoid cysts produce brain distortion and displacement. Unless very large, the cysts do not damage the underlying cortex, and cortical atrophy or gliosis is unusual. In this they must be distinguished from the fun-

damentally different porencephalic cysts which result when a leukoclastic process has produced a focal hemispheric defect permitting communication between a cerebral ventricle and the subarachnoid space.

The rate of expansion of most arachnoid cysts is very slow; however, as has been noted,⁴ the likelihood of intrinsic secretory potential exists, and arachnoid cysts may present as space-occupying lesions causing symptoms such as headache, seizures, cranial nerve palsies. A few cases of unexplained rapid cyst expansion with stroke-like symptoms and death have been reported.⁶ Supracollicular and posterior fossa retrocerebellar cysts are particularly prone to produce hydrocephalus by, respectively, compression of the aqueduct and obstruction of the fourth ventricle outlets. A relation of symptoms to head posture has been observed with some posterior fossa cysts.¹ Large arachnoid cysts in infants may cause thinning and bulging of the skull, although focal neurological signs are uncommon.³ In such cases hydrocephalus secondary to obstruction of cerebrospinal fluid flow may be a greater factor in the head enlargement than the expansion of the cyst itself. Symptoms of spinal cord compression may occur with spinal arachnoid cysts.

Other extracerebral cystic lesions which must be considered in the differential diagnosis of arachnoid cysts are principally subdural hygromas, glial cysts, and epidermoid and dermoid cysts. In the supracollicular region, pineal cysts and cystic teratomas are also possibilities. Epidermoid cysts, dermoid cysts, and teratomas tend to occur in midline locations, and typically in the posterior fossa or spinal canal. The Dandy-Walker malformation is a cystic condition of the posterior fossa fourth ventricle region which must be distinguished from an arachnoid cyst because of its association with hypoplasia of the cerebellar vermis and often with other central nervous system anomalies. Typical radiologic features are usually diagnostic in this condition.⁷ Neurenteric cysts must be considered in cysts of the spinal canal. In contrast to arachnoid cysts, neurenteric cysts usually lie ventral to the spinal cord and are frequently associated with vertebral defects or other malformations.

Although occurring in many of the same locations as arachnoid cysts, glial (glio-ependymal) cysts are distinctive in having glial elements in their walls and by sometimes being lined by ependymal cells. These are most frequent in the supracollicular region and in the posterior fossa and are rare in the spinal canal. They are considered non-neoplastic, and they have much the same clinical import as arachnoid cysts.

Arachnoid cysts are benign and generally carry an excellent prognosis. Surgical intervention is probably not warranted in asymptomatic cysts.⁵ For symptomatic cysts the treatment is drainage and resection of a portion of the cyst wall. Shunting procedures may be required if hydrocephalus is present.

Summary

Primary cysts of the arachnoid membrane may occur at a variety of sites in the cranial and spinal meninges. Many are asymptomatic, and, as in a case illustrated, may be an incidental finding on a CT scan. Others enlarge, possibly due to an intrinsic secretory capacity of the cyst-lining cells, and may produce symptoms of a space-occupying lesion.

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2500 North Statc Street (39216)

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Address of the President

GERALD P. GABLE, M.D.

Hattiesburg, Mississippi

ON THE BALANCE SHEET of time, one of the liabilities of growing older is that the years slip by so quickly and seem so much shorter than they used to be. It seems like only a few short weeks ago since I ascended this podium to accept from Carl the presidency of this organization, and now we come to the end of another year. It has been such a brief but rewarding and educational experience. I hope that I have justified the faith which you placed in me by electing me to the office, but as always, the clock and the calendar see to it that there is never time to do all the things which you plan to do.

Through the efforts of the Board, the House of Delegates, and the tireless efforts of many committee members, we have had a very fruitful year and I would briefly like to review for you some of your accomplishments.

First and foremost, after a long and costly court battle through all the state courts, and even in the federal courts and back to the State Supreme Court, the constitutionality of the right of this association to nominate members to the State Board of Health, as challenged by former Governor Finch, has been upheld in our favor. Since the membership of this organization is open to qualified physicians and osteopaths of all races and creeds, I hope that the charges of racial discrimination will never again be leveled against this association for any ulterior or other motives.

Each year, for the past several years, it has been necessary for the association to protect itself and our patients from the efforts of the optometrists to get a foot in the legislative door to be allowed to practice medicine without benefit of equal educational requirements. This year, through the efforts of many of you to actively communicate with your senators and representatives, this legislation was resoundingly defeated.

Due to the active participation of MSMA members and their spouses in last year's legislative races, our MPAC supported 27 senatorial candidates, 17 of

whom were elected, and 36 candidates for the House, 26 of whom were elected. We did this with about half of the physicians participating in MPAC. Just think what we could have accomplished with total membership participation!

This year, for the first time in the history of our state, we have a certified forensic pathologist as State Medical Examiner, due largely in part by the MSMA House of Delegates in 1974, which urged enactment of this legislation. Now let us all support Dr. Spruill in her new office to rectify the archaic coroner system with which we have been burdened for so long.

The Disabled Physicians Program implemented by the House of Delegates in 1978 came to full fruition in the past year, rehabilitating physicians in need of this service. If any of you are in need of this service or know of a fellow physician who is, I hope that you will contact MSMA headquarters to avail them of this service.

Many other programs have been instituted this year, such as the statewide survey to determine our health care needs; the development of an Action Plan for Physician Recruitment for the areas of our state in need of more physicians; the participation in the program to improve health care in jails; the establishment of a committee to study federal and state health programs; and the conducting of practice management workshops for physicians and their office personnel.

Now that we have addressed ourselves to some of these problems and their solutions, what do we see in the future as we gaze into our crystal ball? We are living in a very fluid and changing world, always evolutionary and sometimes revolutionary. The secure practice of medicine as we have known it for the past 35 years, guided and controlled by the profession, is no longer inviolate.

We are living in a consumer oriented and politically oriented society in which we are inexorably linked to the body politic. I can assure you that there are literally thousands of bureaucrats and politicians, from Washington on down, who plan to change drastically the manner in which you live and practice medicine today. No longer are we referred to as a profession. Instead, we are now considered a "ser-

President, Mississippi State Medical Association, 1979-80.
Read before the House of Delegates, 112th Annual Session,
Biloxi, May 1, 1980.

vice industry'' second only in size to the agricultural industry.

The cost of medical care for the average American family now approximates 10 to 15% of the family's annual income. No longer do you have a one-on-one doctor/patient relationship with the patient personally responsible for your fee. Instead, the responsibility for the majority of your medical fees is assumed by a third party payor.

Industry and labor are interested in health care costs, because they determine how they negotiate union and industry health insurance contracts and what they are getting for their insurance dollar. Health care costs are therefore scrutinized very closely to avoid unnecessary medical care expenditures. When Uncle Sam is the third party payor, he looks just as closely at health care costs as he looks to Litton Industries for the cost of a destroyer or to General Motors for the cost of a jeep or staff car and expects us to deliver medical care to specifications just as rigid as industrial specifications.

The National Health Planning and Resources Development Act, passed by your Congress, mandates that each state set up a Health Systems Agency controlled by a majority of consumers to determine how, when and where you practice medicine; yet, we have had difficulty in finding physicians interested in getting elected to physician slots designated in their local sub-area councils.

You say that you didn't realize that all of this was going on "out there in the real world"? Then I implore you to shed your apathy. Come in off the golf course or tennis court and take time out of your practice to become involved and participate in your medical association's efforts to change these plans.

If you don't like what is being done to you by our politicians and bureaucrats, then take the time to communicate with them and make your views known, for after all, you control *their* destiny by your vote and your patients' votes which you influence daily in your practice.

Let us unite in an organized medical effort as we chart the course of our ship through the turbulent seas of change which lie ahead, so that we, as professionals, can control our ship rather than leave its controls to those less qualified and experienced.

When you hear political or other critics expounding unjustly on the quality and cost of modern day medical care, take the time to remind them what a great job our profession has done in the past 35 years to eliminate most infectious diseases and offer our patients a quality and caliber of medical care unequalled anywhere in the world.

There are two medical needs within the state for

which I would make recommendations:

(1) Despite the efforts of the Disabled Physicians Program, there still exists in our ranks a small number of physicians, both within and outside our association membership, who should be evaluated for disqualification from further medical practice because of physical and emotional reasons which may jeopardize the welfare of their patients. These should be reported by the membership to the Board of Trustees and the State Board of Health. We owe to our patients the responsibility for policing our own ranks.

(2) There is duplication of health care planning and delivery between federal and state programs in our state, and I would recommend that the Committee on Federal/State Programs make an indepth study of the statutory authority for this duplication with recommendations to the Board of Trustees as to solutions.

On behalf of my wife, Patsy, and myself, I would like to thank each of you for the many courtesies which you have shown us during the past year.

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Symposium on Gynecologic Cancer

August 20-21, 1980

Holiday Inn Downtown

Jackson, MS

Guest speakers will include: Dr. Saul Gusberg, president of the American Cancer Society and professor of obstetrics and gynecology, Mt. Sinai School of Medicine, New York, NY; Dr. Luther Brady, professor of radiotherapy at Hahneman University School of Medicine, Philadelphia, PA, and vice-chairman of the Gynecologic Oncology Group; and Dr. Clarence Ehrlich, associate professor of obstetrics and gynecology and director of gynecologic oncology, Indiana University School of Medicine, Indianapolis, IN.

Other faculty from the University of Mississippi School of Medicine include: Dr. Richard Boronow, clinical professor of obstetrics and gynecology; Dr. John Mladineo, assistant professor of obstetrics and gynecology and director of gynecologic oncology; and Dr. Tate Thigpen, associate professor of medical oncology.

Co-ordinator: Dr. Ralph Vance, chairman of the Professional Education Committee of the American Cancer Society, Mississippi Division and assistant professor of medicine, University of Mississippi School of Medicine.

Co-sponsored by: the American Cancer Society, Mississippi Division; the University of Mississippi School of Medicine; and the University of Mississippi Medical Center Division of Continuing Health Professional Education, in conjunction with the annual meeting of the American Cancer Society, Mississippi Division.

Application has been made to AAFP for 8.25 prescribed hours of credit.



The President Speaking

Government Involvement in Medicine

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

With the advent of Medicare in 1965 our government stated that it wanted the best medical care available for all of its citizens over 65 years of age. Need was not to be considered. Since this beginning, many changes have taken place. There is Medicare's sister program for the poor — Medicaid. CHAMPUS, the program for military dependents, is with us, and there are many other programs such as the Community Mental Health Program and the Rural Health Initiative, to mention a few. As you can imagine, the cost of all these programs is astounding. In 1977 the nation spent approximately \$185 billion, or \$740 per person. Congress is concerned because government is paying 42% of this.

We have heard much about the escalating cost of medicine; however, in my opinion, medicine is still a bargain when compared to the rising costs of other goods and services which have not advanced in quality as has medicine. In any event, with government paying its share, there was an obligation to try to control medical costs. From the beginning an attempt was made to control costs by establishing a fee schedule of some type. Other stipulations such as "medical necessity" were added. We are all familiar with these so they will not be restated here.

Now, with health services being utilized more and more, which everyone except the government apparently knew would happen, other means must be considered to control the cost of medicine. The easiest way, but probably the worst, is to not make the services available. This is exactly the path that the government is taking. In 1974 Congress enacted a mandatory health planning program: the National Health Planning and Resources Development Act of 1974, better known as Public Law 93-641. This brought into existence Health Systems Agencies (HSAs) for every health service area within a state and also mandated the formation of a Statewide Health Coordinating Council (SHCC) and a State Health Planning and Development Agency (SHPDA).

There are many other ramifications of Public Law 93-641, but the two agencies that we are concerned with at the moment are HSA and SHPDA. These are the two which control the Certificate of Need process. Under Certificate of Need, guidelines have been established for the number of hospital and nursing home beds per thousand population as well as limits on equipment. A new aspect is that any new institutional service generating over \$75,000 a year in revenue must get a certificate of need. How can medicine continue to develop? Who is to say that one area should have better health service than others? Why should our elderly who are already in nursing homes be allowed to remain while others who now have the need for such service cannot be admitted because of a shortage of beds?

In 1976 Mississippi, under the direction of Governor Finch, decided to have only one HSA. The Mississippi State Medical Association at that time requested that the governor establish more than one HSA in Mississippi. It was thought that more local people would be involved and that the potential for central political control would be diluted. As it is now, Mississippi has a State Planning and Development Agency as well as a statewide Health Systems Agency. MSMA would like to see Governor Winter designate three or four HSAs in Mississippi.

If a Certificate of Need is approved by the HSA, then it goes before the State Health Planning and Development Agency (SHPDA). The members of this body are appointed by the governor, lieutenant governor, speaker, secretary of state, and the chief justice of the supreme court. The decisions of the SHPDA are then subject to approval by the Secretary of the Department of HHS. This is another criticism of the law — it actually bypasses state authority in matters of health care delivery. The federal government's percentage of health care expenditures is high enough to provide incentive to state government to meet the federal guidelines.

Since all of these agencies must have more consumers than providers, we as a medical profession must get involved and see that we have good leadership at all levels. We must protect the profession because this will assure good medical service for our patients.

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EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 7

JULY 1980

Bonanza or Boondoggle?

A recent report distributed by the Mississippi Rural Health Association indicates that there are now some 24 federally funded and/or staffed health clinics in Mississippi serving residents in 62 of the state's 82 counties.

What impact this recent phenomenon will have on these counties' attractiveness as practice locations for the some 150 medical students the University of Mississippi School of Medicine is producing annually becomes a serious question for the future.

There are also other medical socioeconomic issues involved. The federal health dollar is not endless, as witnessed by the current cuts in federal health programs being made by Congress. Furthermore, there is as yet no general evidence that the federally funded health clinics can eventually become self-supporting. Cost figures indicate that the clinics are being federally funded at this time up to \$26.00 per patient visit to a nurse practitioner and \$68.15 per patient visit for a whole range of "health care" services. This compares to the \$10-15 and \$9 per visit fee paid to physicians in Mississippi by Medicare and Medicaid respectively. What is now a federal bonanza could become a state and local boondoggle. — C.L.M.

Second Class Medical Care

A cruel hoax has been perpetrated by the Government upon the recipient of Medicaid. The Medicaid bureaucracy is doing its best to see that there will continue to be two levels of medical care, and that the Medicaid patient will remain a second class citizen.

Recognizing that a crisis does exist, I would hope that some of the anger expressed at the medical profession could be directed at the governmental agency which has ordered that care be provided, but failed to provide the necessary funds to pay for that care.

I believe that the Medicaid patient is entitled to the

same "first class" medical care as the rest of my patients. If the Government holds out that promise to the indigent, it must be prepared to back it up. I join with all thoughtful people who condemn the abusers of the system, and ask that we all join in an effort to urge the Government to show that it intends to make it work, and fulfill its promise, which until now has been a hollow one.

Editorial Note: As previously reported in JOURNAL MSMA, the Mississippi Medicaid Commission has placed new restrictions on Medicaid benefits effective July 1, based on budgetary considerations. The restrictions will no doubt result in new demands on physicians and other health resources. The editorial above, written by Dr. Robert A. Gladstone and reprinted from the Journal of the Florida Medical Association (January 1980), seems particularly appropriate at this time to indicate both the problem and its pervasiveness. — C.L.M.

Use of Aspiration Cytology In Diagnosis of Breast Cancer

Most surgeons are reluctant to do a radical mastectomy on a patient with obvious far-advanced carcinoma of the breast without first doing a biopsy for frozen section diagnosis. A fine needle aspiration of the breast mass under local anesthesia provides a simple, quick and relatively painless method of confirming the diagnostic impression.

This is usually an office procedure. A small skin wheal of local anesthesia is produced over the breast mass. Using a 21-gauge needle affixed to a 10 cc syringe, the mass is aspirated in several planes and the resulting fluid smeared on a slide. Smears are air-dried, mounted and stained by the Diff Quik method and examined immediately by the pathologist. If malignant cells are seen, a diagnosis of cancer of the breast is available in a matter of five to ten minutes. Thus, the diagnosis can be discussed with

EDITORIALS / Continued

the patient and plans made for a radical mastectomy.

It is estimated that at least thirty minutes of operating-anesthesia time is saved by eliminating the need for biopsy and frozen section in the operating room. Should the smears be normal or merely suspicious for a malignancy, a biopsy-frozen section will still be necessary to confirm the diagnosis before doing a mastectomy. However, approximately 50% of suspicious solid breast nodules will yield a positive cytological diagnosis.

Close cooperation between the surgeon, the radiologist reading the mammography, and the cytopathologist is necessary for success in this procedure; but it can save the patient, the surgeon, and the hospital both time and money.

G. H. MARTIN, M.D.
Vicksburg, MS
Associate Editor

Medico-Legal Brief

Hospital Reasonable In Denial Of Privileges To Podiatrist

A podiatrist who was denied hospital staff privileges was not denied equal protection of the law or due process, a federal appellate court in Georgia ruled.

In 1973, the podiatrist sued the county hospital because he was denied privileges. The federal trial court dismissed the action in October 1973. The podiatrist appealed, and the appellate court reversed the decision in part. The podiatrist's equal protection claims were without merit because podiatrists and fully licensed physicians are not "equally situated," the court said.

The appellate court did recognize, however, that the podiatrist possessed a liberty interest sufficient to require a hearing before the medical-dental staff and the hospital authority on his application for privileges. This opinion was rendered in 1975.

Subsequently, the podiatrist was provided hearings before the medical-dental staff and the hospital authority. The medical-dental staff recommended, and the hospital authority decided not to amend the bylaws that limited eligibility for membership to fully-licensed physicians and dentists. The podiatrist was given a three-page examination of the reasons for denial of his application. At each stage, the podiatrist had been given notice, the opportunity to be heard, the right to be represented by counsel, the right to present evidence, confront and cross-examine witnesses, and the opportunity to answer questions raised by members of the respective hearing boards, the court observed.

Again, the podiatrist sought review of the hospital's decision by the federal trial court. The hospital's decision was a reasonable one, the court said. Dentists were allowed on the staff because none of the staff physicians with unrestricted licenses engaged in dental medicine, the court observed. Testimony indicated that all functions performed by a podiatrist could be performed by an orthopedic surgeon, however, the court said. Given the choice between placing a podiatrist or an orthopedic surgeon on the staff, the hospital authority and the medical staff could reasonably condition staff membership on the possession of qualifications necessary to treat the whole patient in any set of foreseeable circumstances, the court concluded.

On further appeal, this decision of the District Court was affirmed. — *Shaw v. Hospital Authority of Cobb County*, Docket No. 77-3436 (C.A.5, Ga., March 31, 1980)

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MEDICAL ORGANIZATION

New Health Boards Named By Governor Winter

Governor William Winter has recently appointed a new Board of Medical Licensure and State Board of Health as provided for in legislation enacted by the 1980 Regular Session of the Mississippi Legislature.

The reorganized Board of Medical Licensure consists of nine members selected from nominees submitted by MSMA. Named by Governor Winter were: Drs. Woody Davis, Meridian; Robert B. Townes, Jr., Grenada; W. W. Walley, Waynesboro; Gilbert R. Mason, Biloxi; Charles R. Jenkins, Laurel; R. Fraser Triplett, Jackson; Matthew J. Page, Greenville; John F. Lucas, Jr., Greenwood; and George D. Purvis, Jr., Jackson.

State Board of Health appointees were Drs. Benton M. Hilbun, Tupelo; Joseph R. Mitchell, Gulfport; Wilfred Q. Cole, Jr., Jackson (all physicians); Ms. Freda Bush, a Jackson nurse; Dr. Marshall Fortenberry, a Jackson dentist; Dr. Rayford Edgar, a Water Valley optometrist; Rev. Harry Bowie, a McComb minister; Dr. Frances Coleman, a physiologist and housewife from Ackerman; Mr. Holton Turnbough, a Gulfport radio executive; Mr. Tom Logue, a McComb hospital administrator; Mrs. Henry McKenzie, a Durant housewife; Mr. Obie Clark, a Meridian community services director; and Mr. Clint Johnson, a Leland pharmacist.

The two new state boards officially became operational on July 1. Although now completely separate from the Board of Health, the new Board of Medical Licensure will remain housed at the State Board of Health building in Jackson temporarily.

Dr. Cobb Describes Planning Needs At National Public Health Meet

"The assumption that DHEW can fill in the gaps and knit together local health service resources is a delusion and results in an administrative monstrosity," State Health Officer Alton B. Cobb told delegates to the National Public Health Leadership Conference.

The conference, part of the American Public Health Association, met June 1-3 in Washington. Dr. Cobb served as a resource panelist on federal and state programming.

"Health planning at the local and state level must

be professionalized," said Mississippi's health officer. "We must take a rational, non-political approach; it's a very technical business."

Dr. Cobb called for consumer input, "but not domination," into the tough, complex decisions that must be made in planning.

"Allocation of health service delivery funds should be made to the states, and they should be permitted to apply those resources to such activities and programs that planning has identified as the most cost-effective toward improving the health of the public," he insisted. "States should be encouraged through design of federal health efforts to involve health departments in total community health services. Local governmental presence for public health must be maintained and strengthened."

Dr. Cobb cited the decreased support for all formulae grant funding to the states for health and mental health as a discouraging sign. He criticized increased emphasis on special, narrow categorical projects and the federal government's failure to achieve coordination between existing grant and project programs.

"The division of public health/mental health programs and services at the local level weakened and fragmented human services and local public health agencies," he said. "Local and state general-purpose government was by-passed in favor of what many have called para-governments, semi-public leaders operating independently with federal subsidies. Proliferation in the 1960s of para-governments in health manpower programs, education, and related areas further weakened the roles of state and local governmental systems for planning, coordination, and administration of public services.

"In the early 1970s we saw less emphasis on direct federal community activity and more emphasis on development of state and local capacity and systems building. Under Carter, we seem to have shifted again toward greater emphasis on projects, less on traditional programs (such as maternal child health) and formulae grants," Dr. Cobb continued.

The State Health Officer joined David B. Walker of the Advisory Commission on Intergovernmental Relations in calling the current emphasis a "vast muddling of the appropriate fiscal, administrative, and servicing roles of the different governments in the system."

Legislature Passes Health Bills During 1980 Regular Session

Many of the health related bills which passed during the 1980 Regular Session of the Mississippi Legislature are of interest to MSMA members. The 120-day session ended May 9.

Nine counties asked for and received local and private legislation dealing with health care facilities. Three of the counties, Quitman, Lincoln, and Hinds, received authorization to issue bonds or notes to finance repairs or construction of hospital facilities. The other six, Franklin, Monroe, Alcorn, Wayne, Tippah and Greene, obtained legislation which will allow the county governments or hospital trustees to construct and/or lease space for physicians' offices.

As is true every year, several groups of allied health professionals sought to be licensed. Although no new groups were licensed, two boards which had been formed several years ago were given new life by a change in the date of repeal of the law. The Physical Therapy Board and the Council on Speech Pathology and Audiology were both extended for four years. Both boards will come up for review again in 1988.

Chiropractors

Chiropractors were given "insurance coverage equality" under H.B. 393. The bill, as introduced, would have required Medicaid to reimburse for chiropractic services. As it finally passed, however, the legislation calls for chiropractors to be reimbursed by private insurance carriers for services covered in health insurance contracts which are within the lawful scope of a licensed chiropractor's practice. This legislation will affect about 15% of the private carriers in this state since 85% were already covering chiropractic services.

Medicaid

Financing of the Medicaid program was again the subject of much controversy. Faced with a deficit appropriation at the beginning of the session, lawmakers settled on an appropriation for FY 1981 of \$58.5 million instead of the \$62.5 million requested by the Medicaid Commission. The Commission has already instituted several cuts in the program, including the controversial 50¢ co-payment on prescriptions.

The legislature passed two other bills which change the Medicaid program. One removes the mandatory generic substitution requirement for Medicaid prescriptions and provides for the Commission to reimburse for the generic unless the consensus of competent medical advice is that the trade

name drug is substantially more effective. Additionally, pharmacists will now be able to realize some of their cash discounts for prompt payment, which they had not been allowed to do during the past year. Eligibility standards for Medicaid are changed under S.B. 2118. Previously, eligibility certification for Medicaid had been done by approximately 300 employees of the state welfare department. Now, eligibility will be based on eligibility for Supplemental Security Income under Social Security. This bill is expected to add approximately 6,000 people to the Medicaid program.

State Board of Health

The State Board of Health was reorganized under S.B. 2773, and a new board of Medical Licensure was created under S.B. 2781. The new Board of Health is composed of 13 members who are consumers and providers, two from each of the state's five congressional districts and three from the state at large. All were appointed by the governor and now face Senate confirmation. The new Board of Medical Licensure consists of nine members appointed by the governor, all of whom must have been in practice for at least six years. The appointments were made from nominations submitted by MSMA, and the appointees face Senate confirmation.

Although funds were in short supply, some health programs in the state received much-needed funding. The State Board of Health received appropriations for tuberculosis programs, genetic screening programs, and hypertension control. Also, the Department of Mental Health received monies for alcohol and drug treatment programs, financed by a tax placed on alcoholic beverages. The University of Mississippi medical school's request for a new obstetrical wing was not granted, but the University did receive appropriations permitting the expansion of its faculty and enabling the hospital to continue at its present level of service.

Certificate of Need

Mississippi's Certificate of Need law, passed last year to conform to amendments to the federal health planning law, was amended under H.B. 459. The bill places a one year moratorium on certificates of need for skilled nursing home facilities, intermediate care facilities, or intermediate care facilities for the mentally retarded. During the moratorium period (July 1, 1980 through June 31, 1981), the Health Care Commission is to study the impact of such new facilities as well as the ability of the Medicaid program to reimburse the facilities. The Commission's findings will be presented to the 1981 session.

Other bills passed by the legislature include:

—H.B. 595, which provides for reciprocity licensing of Canadian physicians who have graduated from accredited medical schools and have been licensed in Canada (a privilege already extended to Canadian physicians in approximately 35 other states);

—H.B. 728, which provides that anyone who has a drug addiction problem may admit himself for treatment;

—H.B. 828, which establishes the Governor's Council on Physical Fitness and Sports, which, among other things, is to stimulate physical fitness research and educate Mississippians on the subject of physical fitness;

—H.B. 842, which allows blood storage facilities to keep blood a few days longer than previous storage limits;

—H.B. 947 which allows mortuary science programs at the state's junior colleges to receive dead bodies provided that the University medical school does not need them for medical students;

—H.B. 2570, which provides for the Board of Health to adopt rules and regulations equivalent to those set forth by the Environmental Protection Agency dealing with disposal of hazardous wastes.

Field Community Hospital Sponsors Lecture Series



More than 200 guests heard Dr. Alton Ochsner discuss "The Future of Medicine in America" during the Second Annual Distinguished Lectureship Series sponsored recently by the Field Memorial Community Hospital. Dr. Ochsner, third from left, is founder of Ochsner Foundation Hospital in New Orleans and emeritus professor of surgery, Tulane University School of Medicine. Field Hospital representatives with him, from left, are Mr. Andrew Truelove, administrator, Dr. Richard J. Field, Jr., program chairman; and Dr. John B. Flood, chief of staff.

JULY 1980

IN APPRECIATION

The many fine technical exhibitors who participated in the exhibit during the recent Mississippi State Medical Association 112th Annual Session are deserving of our recognition and a hearty "Thank You!" The presence of these exhibits enhanced the educational quality of our meeting.

The firms listed below participated in our 1980 annual meeting exhibit and we voice a collective expression of our sincere appreciation. May we also suggest that you retain this listing and express your personal appreciation when their representatives call upon you.

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Mississippi Home Health Association, Hattiesburg, MS
Mississippi Medical Fraternal & Educational Society, Jackson, MS
Navy Recruiting, Memphis, TN
Niagra Therapy, Kenner, LA
Pennwalt RX Division, Rochester, NY
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NEW MEMBERS

ARNETT, WILLIAM RAY, Hattiesburg. Born Atlanta, GA, July 14, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned and family practice residency, University Medical Center, Jackson, 1975-78; elected by South Mississippi Medical Society.

CARTER, RICHARD CLARENCE, JR., Kosciusko. Born Tupelo, MS, March 21, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned Roanoke Memorial Hospital, Roanoke, VA, one year; family practice residency, same, 1977-79; elected by North Central Medical Society.

COWEN, GEORGE DAVID, Hattiesburg. Born Salt Fork, OK, June 16, 1939; M.D., Tulane University School of Medicine, New Orleans, 1970; interned Letterman Army Medical Center, San Francisco, one year; internal medicine residency, same, 1971-73; cardiology fellowship, same, 1973-75; elected by South Mississippi Medical Society.

CUNNINGHAM, JERRY MILTON, Greenville. Born Baldwin, MS, Nov. 13, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University Medical Center, Jackson, one year; internal medicine residency, same, 1975-77; elected by Delta Medical Society.

GROFF, GARY H., Pascagoula. Born New Orleans, April 10, 1947; M.D., Louisiana State University School of Medicine, Shreveport, 1974; interned University Medical Center, Jackson, one year; family practice residency, same, 1974-77; elected by Singing River Medical Society.

GRUICH, CHARLES J., Biloxi. Born Biloxi, MS, Sept. 22, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1978; interned Louisiana State University Medical Center, Shreveport, one year; elected by Coast Counties Medical Society.

HOPPER, WILLIAM CLAYTON, JR., Gulfport. Born Memphis, TN, Sept. 23, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned University Medical Center, Jackson, one year; orthopedic surgery residency, same, 1972-76; pediatric orthopedic surgery fellowship, Scottish Rite Hospital, Atlanta, GA, 1976-77; elected by Coast Counties Medical Society.

KAPP, JOHN PAUL, Jackson. Born Galax, VA, Feb. 22, 1938; M.D., Duke University School of Medicine, Durham, NC, 1963; interned surgical and

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AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication. Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

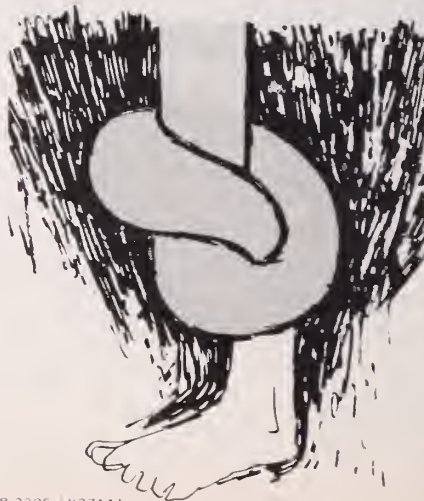
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each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease...consider Quinamm...simple, convenient dosage—usually just one tablet at bedtime...can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

A woman with dark hair, wearing a white chef's coat, is focused on her work in a kitchen. She is leaning over a large, dark, rectangular tray or pan that is filled with rows of small, golden-brown, elongated food items, possibly fried fish or vegetables. The lighting is warm and focused on the food, creating a sense of depth and texture. The background is dark and out of focus, emphasizing the woman and her work.

**getting back
to business**

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

**for moderate anxiety
with depression**

dual-action
Triavil[®]
containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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*Please see the following page
for a brief summary
of prescribing information.*

by providing symptomatic relief
of moderate anxiety with depression

Dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:

TRIAVIL® 2-25: Each tablet contains
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TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdose. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdose of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone. **Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmic involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect, hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste, diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness, fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdose should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdose with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

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medical college of Virginia; general surgery residency, Duke University, Durham, NC, 1964; neurosurgery residency, same, 1964-69; elected by Central Medical Society.

KEDDY, DAVID B., Greenville. Born Halifax, Nova Scotia, Dec. 9, 1935; M.D., Dalhousie University Faculty of Medicine, Halifax, Nova Scotia, 1962; interned, same, one year; elected by Delta Medical Society.

LATHAM, WILBUR DARRELL, Jackson. Born Ludlow, MS, July 31, 1927; M.D., Tulane University School of Medicine, New Orleans, 1953; interned Mississippi Baptist Hospital, Jackson, 1953-54; general surgery residency, US Naval Hospital, Great Lakes, IL, 1957-60; plastic surgery residency, University Illinois Hospital, Chicago, 1960-62; elected by Central Medical Society.

MATTHEWS, ARTHUR MORRIS, JR., Gulfport. Born Hattiesburg, MS, Aug. 9, 1946; M.D., Tulane University School of Medicine, New Orleans, 1971; interned Tulane and Charity Hospitals, New Orleans, 1971-72; general surgery and urology residency, same, 1972-77; elected by Coast Counties Medical Society.

MOSES, MICHAEL E., Gulfport. Born Vicksburg, MS, Sept. 21, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned University Medical Center, Jackson, 1972-73; general surgery residency, same, 1973-77; elected by Coast Counties Medical Society.

PATEL, DAKSHA M., Jackson. Born Baroda, India, Sept. 10, 1948; M.D., Grant Medical College, Bombay, India, 1972; interned Brookdale Medical Center, Brooklyn, NY, 1973-74; pediatric residency, Martland Hospital, Newark, NJ, 1974-77; neonatology fellowship, University of Cincinnati, Cincinnati, OH; elected by Central Medical Society.

RICKETSON, GREER HOMER, Jackson. Born Cleveland, OH, Nov. 8, 1944; M.D., Tulane University School of Medicine, New Orleans, 1973; interned Eastern Virginia Medical School, Norfolk, VA, one year; radiology residency, University of Tennessee, Memphis, 1974-75; therapeutic radiology residency, Medical College of Virginia, Richmond, 1975-78; elected by Central Medical Society.

ROUTH, ANUPAM, Jackson. Born Rangoon-Burma, May 9, 1939; M.D., National Medical College, Calcutta, India, 1962; interned District Hospital, United Kingdom, 1966-67; radiotherapy residency, Sheffield Hospital, 1967-70; Sheffield, U.K., radiother-

apy residency, Bristol Hospital, U.K., 1970-73; elected by Central Medical Society.

SMITH, CAROL ANN, Gulfport. Born New Orleans, LA, Feb. 10, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Tulane and Charity Hospitals, New Orleans, 1974-75; emergency medicine residency, same, 1975-77; elected by Coast Counties Medical Society.

WILSON, JOHN DRAKE, Memphis, TN, Sept. 11, 1947; M.D., University of Tennessee College of Medicine, Memphis, 1972; interned University Hospital, Knoxville, TN, one year; surgery and neurosurgery residency, Baptist Memorial Hospital and University of Tennessee, Memphis, 1974-79; elected by Prairie Medical Society.

DEATHS

BEECH, THOMAS RICHARD, Laurel. Born Ellisville, MS, April 16, 1888; M.D., Atlanta College of Physicians and Surgeons, Atlanta, 1913; interned State Charity Hospital, Laurel, MS, 1926-28; E-Ret member of MSMA and AMA; died May 10, 1980, age 92.

CROMEANS, CLAUDE, Belmont. Born Fulton, MS, Oct. 25, 1888; M.D., University of Tennessee College of Medicine, Memphis, 1914; died May 16, 1980, age 91.

MONTGOMERY, DANIEL C., JR., Greenville. Born Greenville, MS, Aug. 13, 1920; M.D., Johns Hopkins University School of Medicine, Baltimore, MD, 1945; interned Union Memorial Hospital, Baltimore, one year; otolaryngology residency, Pennsylvania Naval Hospital, 1946-47; died May 2, 1980, age 59.

PERSONALS

HELEN B. BARNES has been named by Governor Winter to serve as chairman of the Statewide Health Coordinating Council. Dr. Barnes, formerly of Jackson, is now in association with FRANK GARBER of Ocean Springs.

G. WILLIAM BATES of Jackson and UMC presented a paper at the annual meeting of the American College of Obstetricians and Gynecologists in New Orleans in May.

PERSONALS / Continued

JAMES HARDY of UMC gave the Jerome Cochran Lecture at a meeting of the Alabama State Medical Association in Montgomery in April.

FREDERICK HECKLER of Jackson and UMC presented a paper at the April meeting of the Plastic Surgery Research Council in Hershey, PA.

THOMAS HERRIN of Jackson and UMC recently presented papers at meetings on CPR at Georgetown University and Baylor College of Medicine, and spoke at an Advanced Cardiac Life Support meeting in Hattiesburg and a meeting of the American Heart Association in Biloxi.

JACK C. HOOVER of Pascagoula was recently elected chairman of the Jackson County Republican Executive Committee.

WAYNE HUGHES of Hattiesburg spoke on poison control at a meeting of the Magnolia Chapter of the American Association of Medical Assistants.

BOYD A. KELLETT of Hattiesburg announces the relocation of his office for family practice to 3706 Montague Boulevard.

HERBERT LANGFORD of Jackson and UMC chaired a recent workshop session at a symposium on coordinating clinical trials in Philadelphia, PA; lectured at Baptist Memorial Hospital in Memphis; and spoke at a hypertension conference in Williamsburg, VA.

W. H. MERRELL of Jackson has been elected chief of staff at St. Dominic Hospital. He will be assisted by C. E. WALLACE, chief-elect, T. C. TURNER, past chief, and JAMES CROSTHWAIT, secretary.

FRANCIS S. MORRISON of Jackson and UMC chaired a workshop and presented an update on regionalization at the annual meeting of the South Central Association of Blood Banks in San Antonio, and spoke at a recent meeting of the Mid-Atlantic Association of Blood Banks in Richmond, VA.

JOHN MORRISON of Jackson and UMC presented a paper at the May annual meeting of the American College of Obstetricians and Gynecologists in New Orleans.

KARLEEN NEILL of Jackson and UMC presented a paper at the National Conference on High Blood Pressure Control in Houston, TX.

W. J. PATTERSON of Clinton announces the relocation of the Family Clinic to 501 Springridge Road.

ANDREW PARENT of Jackson and UMC presented a paper at an April meeting of the American Association of Neurological Surgeons in New York.

ROBERT SANFORD of Jackson and UMC presented papers at meetings of the Society for University Neurosurgeons in Gainesville, FL, and the American Association of Neurological Surgeons in New York.

A. J. SANTANGELO has relocated his office for the practice of psychiatry to 1201 24th Avenue in Meridian.

J. H. SHOEMAKER of Okolona was named 1980 Outstanding Citizen by the Okolona Chamber of Commerce.

G. V. SMITH of Jackson attended a national meeting of liaison fellows of the American College of Surgeons Commission on Cancer in Chicago in April.

Greenwood Hospital Honors Dr. John F. Lucas, Sr.

Greenwood Hospital recently honored Dr. John Fair Lucas, Sr., for his 44 years of service to the hospital and to Sunflower Countians.

A wing of the hospital has been named the Lucas Wing by resolution of the Board of Hospital Commissioners. A plaque and a portrait of Dr. Lucas will be placed at the entrance to the newly named wing.

Among those paying tribute to Dr. Lucas was Dr. George J. Nassar, chief of the medical staff. He described Dr. Lucas as "an astute diagnostician and a meticulous practitioner of the art of medicine."

"His counsel has always been a source of comfort and reassurance to his fellow physicians," continued Dr. Nassar.

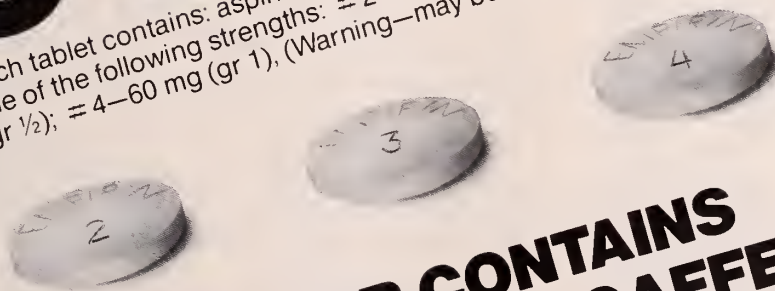
During his 44 years at the hospital, Dr. Lucas served on every committee of the medical staff and was chief of staff in 1955. He was chief of the obstetric and gynecology service for more than 13 years, longer than any other physician has served in that capacity.

Dr. Lucas represented the Mississippi State Medical Association as delegate to the American Medical Association from 1952-1962.

He attended the University of Mississippi and the University of Virginia. He received his M.D. degree from Tulane Medical School and practiced in Greenville for ten years before establishing his practice in Greenwood. He retired from active practice in 1978.

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Release of Medical Records

Frequently, physicians receive requests for a copy or a summary of a patient's medical records. These requests come from insurance companies, employers, and sometimes, attorneys. Often, physicians are not aware of the legal and ethical restrictions and requirements dealing with the release of patient information.

It should be noted that under Mississippi law, medical and/or surgical treatment provided for workmen's compensation claimants is not privileged insofar as obtaining benefits is concerned. The employer or the Workmen's Compensation Commission may require that all medical findings be reported on commission forms and a copy furnished to both the employer and employee.

All other medical and/or surgical treatment is cloaked in the physician-patient privilege, and the

release of information pertaining to the patient's health should be allowed only after certain procedures have been followed. Additionally, the form in which patient information leaves the office is very important.

No information of this type should be released without a signed consent form. To be properly protected, the physician releasing the records should have a form containing the following: the patient's name; the date; to whom the information is being released; and the patient's signature.

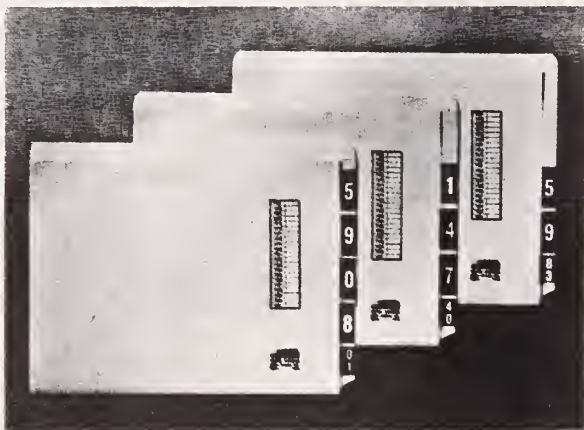
Instruct your office personnel that medical information about a patient should never be given over the telephone. Also, simply making and sending a photostatic copy of a patient's record is not a good idea. In many cases, there may be information in the record that is not relevant to the purpose for which the records are requested. Additionally, many patients, attorneys, or other lay persons would not be able to understand all of the abbreviations contained in a patient chart. In these cases, a brief summary should be dictated and transcribed for release to the requesting party. If, however, the information has been requested by another physician who is now treating the patient, it is probably in the best interests of the patient's health to send a copy of the entire record. *The original record should never leave the doctor's office.*

Be certain to keep in mind that your first responsibility is to your patient's health and your release of medical information may sometimes be critical to further treatment by another physician. Although the records belong to you, the patient has a right to certain information contained therein. Ethically, you cannot refuse to release information when requested in writing by the patient, even if the patient has an unpaid balance for services rendered.

(This month's article was prepared by Bucky Murphy, MSMA general counsel. Please address your practice management inquiries to P.O. Box 5229, Jackson, MS 39216.)

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IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation. The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlori-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted. Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa 19101



FOR MODERATE PAIN

A therapeutic dose of acetaminophen in one tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVER-

DOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977). Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Wyeth Laboratories
Philadelphia, Pa 19101



POSTGRADUATE CALENDAR

July 16-17, 1980

NEWBORN METABOLISM

University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine, School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine, UMC School of Medicine, and Gwen Bussa, R.N., C.N.M., assistant professor of nursing and instructor of obstetrics and gynecology (nurse-midwifery), UMC School of Medicine.

This program will cover the metabolic needs of the term and pre-term infant. It will include fluids, electrolytes and nutritional needs of the well and sick newborn on short and long-term requirements. Limited to 10 participants. Fee: \$50. Credit: 12 contact hours, (1.2 CEU) Category 1 of the Physician's Recognition Award, AMA; AAFP credit applied for.

July 18, 1980

SOUTHERN GENETICS GROUP

University Medical Center, Jackson

Sponsored by the Southern Genetics Group, the University of Mississippi School of Medicine Department of Preventive Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: John F. Jackson, M.D., professor of preventive medicine, UMC School of Medicine.

This program is the Southern Genetics Group's semiannual meeting and is open to all interested health professionals. The group is an informal association of medical geneticists who share a common interest in the understanding, teachings, diagnosis and treatment of genetic disorders. No fee for program, \$5.00 for lunch. Credit: 4.5 contact hours (.45 CEU), Category 1 of the Physician's Recognition Award, AMA.

July 18-19, 1980

ADVANCED CARDIAC LIFE SUPPORT PROVIDERS
COURSE

North Mississippi Medical Center, Tupelo

JULY 1980

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology, the UMC School of Nursing and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Roma Taylor, M.D.

This course is open to physicians, nurses, and allied health personnel who are certified in basic life support by the American Heart Association and who are actively engaged in advanced cardiac life support on a daily basis. Fee: \$100. Credit: Category 1 of the Physician's Recognition Award, AMA; American College of Emergency Physicians credit applied for.

FUTURE CALENDAR

October 7, 1980

MISSISSIPPI THORACIC SOCIETY MEETING
University Medical Center, Jackson

October 20-24, 1980 and January 19-23, 1981

PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

November 6-8, 1980

FAMILY PRACTICE UPDATE
Jackson Hilton, Jackson

it's
the real
thing



70-37

Mississippi Council of
Coca-Cola Bottlers

PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

PHYSICIANS WANTED TO RENT OR LEASE completely furnished 14-room modern clinic in county seat with population 15,000. New 36-bed hospital and 60-bed nursing home. Ill health caused physician to vacate clinic after 25 years successful practice. Call (601) 326-2741 between 8:00 a.m.-6:00 p.m.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available.

Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

BOARD ELIGIBLE OB-GYN concluding 4-year Ob-Gyn residency July 1 seeking solo, association or partnership position in semi-rural area of Southeast. Contact: James D. Long, M.D., 131 Beverly Ave., Norfolk, VA 23505.

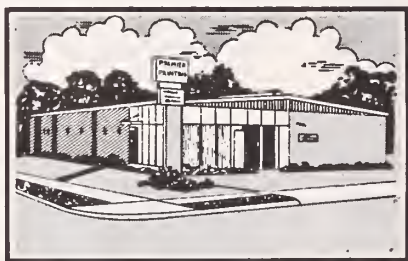
PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstubb Rd., Cortland, OH 44410.

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Index to Advertisers

American Cancer Society, Miss. Division 149
Avis Rent A Car System 8

Boots Pharmaceuticals, Inc. 10A, 10B, 10C, 10D
Burroughs Wellcome Co. 159

Canton Exchange Bank 147
Citizens Bank 19
Coca-Cola 161

Darkroom, Inc. 152

Harreld Chevrolet-Oldsmobile 19

Janssen Pharmaceutica 6, 7

Eli Lilly and Company 18

Merck Sharp & Dohme 156B, 156C, 156D
Merrell-National, Inc. 14, 14A, 156, 156A

Miss. Medical Fraternal and
Educational Society 16
Mississippi Stationery 160

Parke, Davis & Co. 12
Premier Printing 162

Riverside Hospital 17
Roche Laboratories
..... second, third and fourth covers, 3, 4, 14B

Southern Environmental Products 15

U.S. Air Force 11

Wyeth Laboratories 160A, 160B

Thomas Yates & Co. 10

IN CONCLUSION

Citing a "significant national problem," an investigator for the Center for Disease Control outlined a substantial increase throughout the U.S. of strains of ampicillin-resistant Haemophilus influenzae. Clyde Thornsberry, Ph.D., who has been monitoring the strains across the country since 1974, said some hospitals are finding a resistance rate as high as 38%. He recommended that physicians set up a system of regular testing for resistant strains.

The AMA is unable to support Council on Wage and Price Stability guidelines that limit the rate of increase in physicians' fees in 1980 to 6.5%. The rate of inflation appears to be about 18%, the AMA pointed out, and the COWPS wage guidelines for industry are 7.5% to 9.5%. At a meeting of leaders of the Voluntary Effort to Contain Health Care Costs and HHS officials, the AMA said it would continue to urge individual physicians to exercise restraint.

A survey being conducted by the American Academy of Pediatrics will determine the extent to which office based primary care pediatricians participate in Medicaid and the relationship between key policy characteristics of state Medicaid programs and physician participation. The two-year project, funded by the Federal Health Care Financing Administration, will review Medicaid programs in 13 states selected for divergent characteristics.

Cigarette smoking is the true culprit in causing lung disease in coal miners, says a recent report in JAMA. And the incidence of truly disabling Black Lung Disease among miners has been greatly overstated. In an accompanying editorial JAMA editor Dr. William R. Barclay, himself a specialist in diseases of the chest, points to difficulties in administering the Black Lung Benefits Reform Act of 1977 and to the possibility of "improper drains on the public treasury."

The Medicare fee index for physician charges during the year beginning July 1 will be set at 165.8 (using 1973 as a base year); the current index is set at 153.5 which allows for an increase of 8.15%..... MSMA and Central Medical Society will co-sponsor an HMO Informational Seminar in Jackson, September 6, at the Jackson Sheraton Motor Hotel. Nationally known HMO experts will speak. Reservations are on a first come, first serve basis.

LIBRARY

AUG 1 1980

NEW YORK ACADEMY
OF MEDICINE

Only Valium® (diazepam/Roche)
is indicated in anxiety
and tension states
and as an
adjunct in the
relief of skeletal
muscle spasm

Before prescribing, please
consult complete product in-
formation, a summary of which
follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

General guidelines
for the prescribing
and appropriate use of
minor tranquilizers

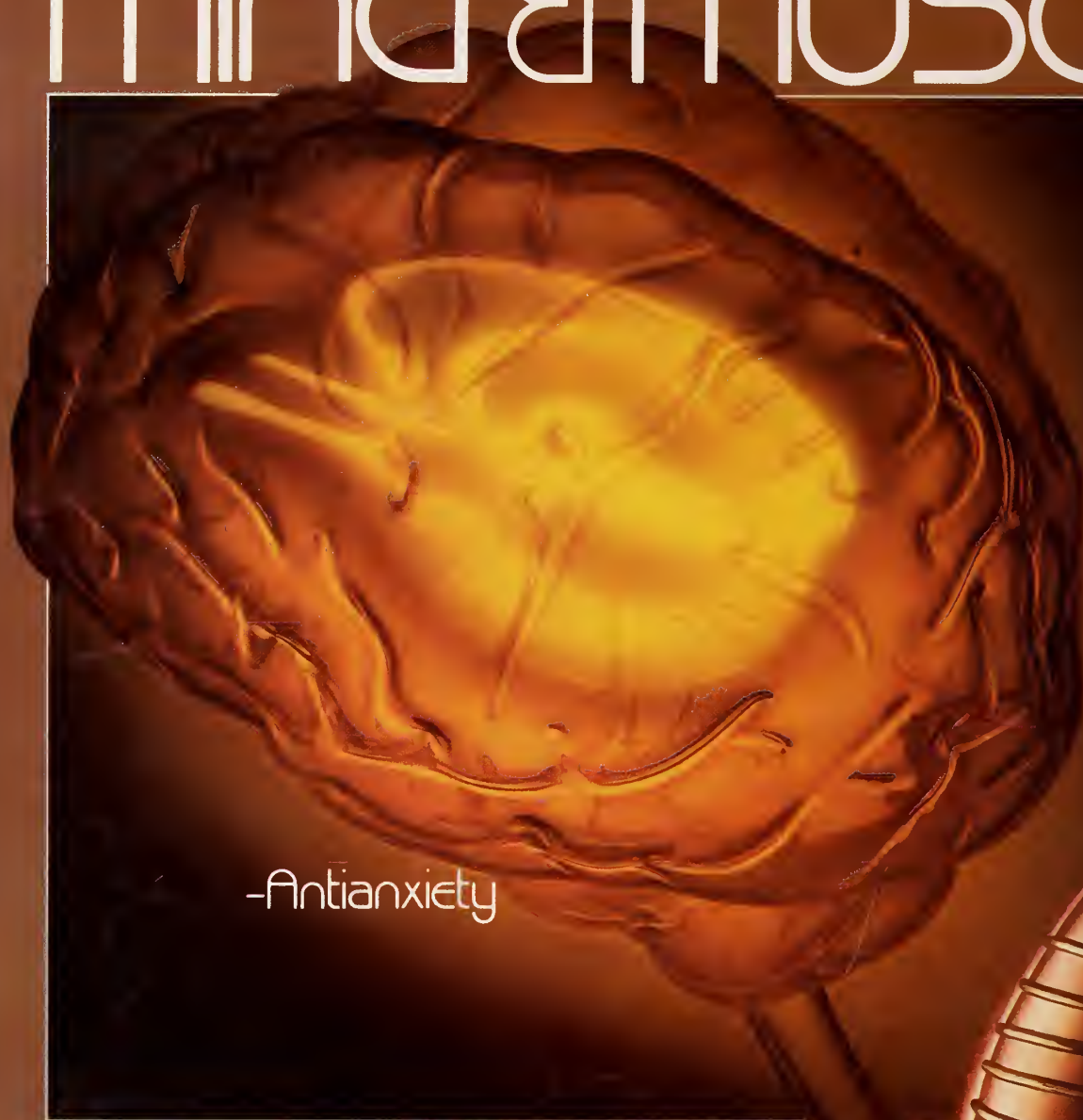
- Individualize dosage for maximal beneficial effect.
- Prescribe the specific quantity needed until the next checkup period, schedule frequent, periodic reexaminations to monitor results of therapy.
- Establish treatment goals and gradually discontinue medication when these have been met.
- Avoid prescribing for individuals who appear dependency-prone or whose histories indicate the potential for misuse of psychoactive substances, including alcohol.
- Caution patients against engaging in hazardous occupations requiring complete mental alertness such as operating machinery or driving.
- Advise patients against the ingestion of alcoholic beverages while undergoing therapy with minor tranquilizers.
- Counsel patients to follow label directions, keep medication out of children's reach, and dispose of unused or old medication.
- Caution patients against giving medication to others.
- Avoid abrupt cessation of extended therapy by tapering dosage before discontinuing medication.

ROCHE

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Only Valium® (diazepam/Roche)
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-Skeletal
muscle
relaxant

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Valium®
diazepam/Roche

Indicated in anxiety and tension
states and as an adjunct in the
relief of skeletal muscle spasm

Please see summary of
product information
on preceding page.

ROCHE

August 1980

BALCONY

Journal of the
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Mississippi

(ISSN 0026-6396)

Contents:

**Profile of the Renal
Colic Patient**

**Ct in Intracranial
Abscess**

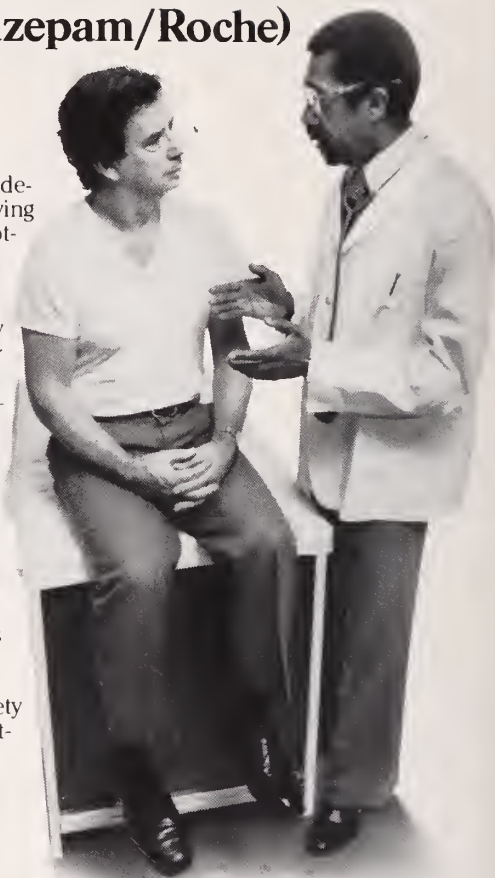


Monitoring patient response to Valium® (diazepam/Roche)

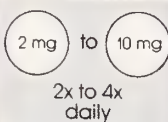

Assessing initial response to therapy



During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST
	

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

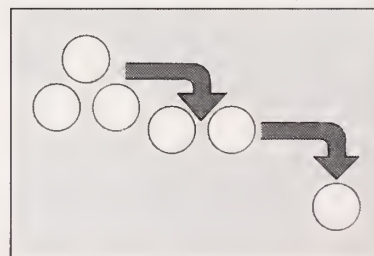
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

2-mg, 5-mg, 10-mg scored tablets
Valium®
diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety



See the following page for a summary of product information.

Valium® (diazepam/Roche)®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age.

Acute narrow angle glaucoma may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d. alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d. adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

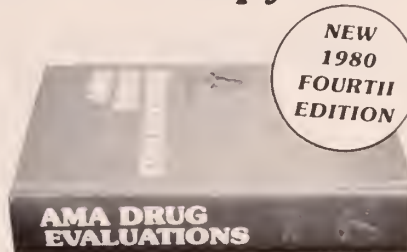
Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



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JOURNAL of the **MISSISSIPPI** State Medical Association



August 1980, Volume XXI, Number 8

ORIGINAL PAPERS

- 163** Profile of the Renal Colic Patient
J. P. ELLIOTT, M.D., J. W. EVANS, M.D., J. O. GORDON,
M.D. and L. O. PLATT, M.D.
- 167** Radiologic Seminar CCV: CT in Intracranial Abscess
HILTON W. PITTMAN, M.D. and WILLIAM F. RUSSELL, IV,
M.D.

SPECIAL ARTICLE

- 171** Dr. Hallie Garrett: Corinth Physician
BEULAH M. D'OLIVE PRICE

EDITORIAL

- 713** Spotlight on HMOs
MYRON W. LOCKEY, M.D.

THIS MONTH

- 172** The President Speaking — AMA Meeting: Opportunity
for Solving Problems, PAUL H. MOORE, M.D.
- 173** Practice Management Workshop
How Long to Keep Medical Records
- 175** Medical Organization
- 180** Recollections — From the August 1960 JOURNAL MSMA

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Laurel Student Receives UMC Leathers Award



Dr. Richmond Lavern Alexander, III, (center) received the Waller S. Leathers Award in 1980 University of Mississippi Medical Center Commencement ceremonies June 1 at City Auditorium. Dr. Alexander was the graduating medical student with the highest academic average. With him are University of Mississippi Chancellor Porter L. Fortune, Jr., and Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean. Dr. Alexander, son of Dr. and Mrs. R. L. Alexander, Jr., of Laurel, received his degree *summa cum laude*.

POSTGRADUATE CALENDAR

October 7, 1980

MISSISSIPPI THORACIC SOCIETY MEETING
University Medical Center, Jackson

October 20-24, 1980 and January 19-23, 1981

PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

November 6-8, 1980

FAMILY PRACTICE UPDATE
Jackson Hilton, Jackson

November 14-15, 1980

NEUROSURGERY INTERNATIONAL CONFERENCE
Holiday Inn Downtown, Jackson

December 4-5, 1980

MISSISSIPPI PERINATAL POSTGRADUATE COURSE 1980
Holiday Inn Downtown, Jackson

For information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

Tenuate®

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY DN PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga M.T., O'Dillon J., Dillon R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

**Overweight may not always be simple...
complications can develop*.
Complicated or not...**

Tenuate[®] Dospan[®] [Ⓒ] **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page.

α

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Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

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- Catapres can be useful even in these patients with:

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

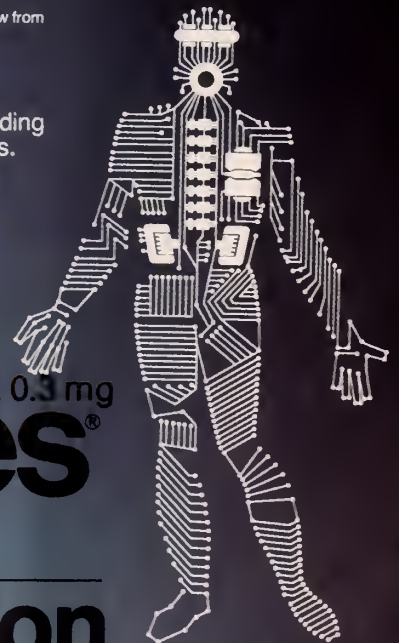
*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new
0.3 mg tablets**

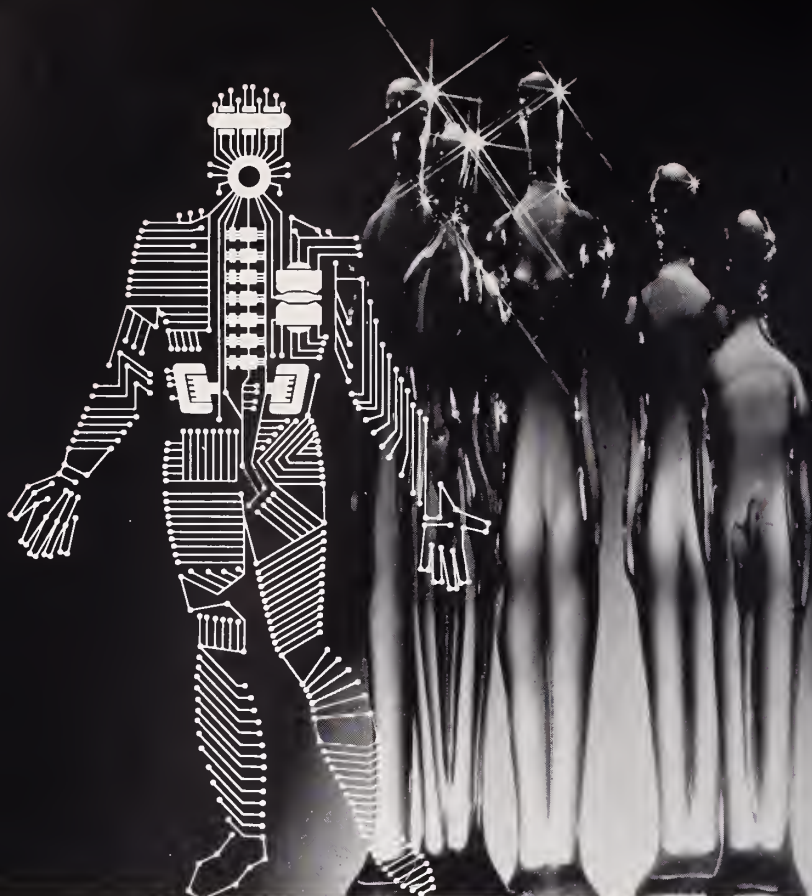
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(clonidine HCl)
Hypertension



α

The Alpha Advantage: It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg
Catapres
(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlor-thalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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Dr. Fox Named SBH Family Services Chief

A Mississippi-born physician with specialty training in pediatrics and preventive medicine has been named chief of the Mississippi State Board of Health Bureau of Family Health Services.

State Health Officer Alton B. Cobb announced the appointment of Dr. Claude Earl Fox, III, effective July 1.

No newcomer to public health in Mississippi, Dr. Fox has already laid plans to lead to an integration of services within the agency and with other health care providers to provide a total system of preventive and primary care to Mississippi people.

"We must rethink our involvement and, with additional support through the existing health care system, broaden our scope of services," he said. "Traditionally, the public health system has concentrated on preventive services with no primary care; some systems give acute care with little or no emphasis on prevention. The ideal system would be both. It's exciting to see if we can develop a total system for comprehensive quality care through close cooperation and coordination between the public and private systems." The Charleston native earned his M.D. degree at the University of Mississippi School of Medicine in 1972. He is a graduate, with distinction, of Mississippi College.

Dr. Fox interned at the University of Mississippi Medical Center (UMC) and did a pediatric residency at UMC and Johns Hopkins Hospital and a preventive medicine residency with the Mississippi State Board of Health.

The new bureau chief served three years as district health officer in what was then Public Health District III. The district, with headquarters in Tupelo, included Lafayette, Union, Pontotoc, Lee, Itawamba, Monroe, Chickasaw, and Calhoun Counties. During that time he was also medical administrator of the Pilot Regionalized Perinatal Project in Mississippi.

He is a former pediatric consultant to the North Carolina Department of Health, having earned a master's degree in public health from the University of North Carolina at Chapel Hill. Dr. Fox also served as local health officer in Tallahatchie, Grenada, and Coahoma Counties.

A fellow of the American College of Preventive Medicine and candidate member of the American Academy of Pediatrics, he is a licentiate in both the public health and preventive medicine sections, American Board of Preventive Medicine. Dr. Fox is on the attending staff, Department of Pediatrics, University Medical Center, and an adjunct professor

in the School of Health Administration, University of Mississippi.

He is past chairman of the Preventive Medicine Section, Mississippi State Medical Association; past chairman of the Administrative Section, Mississippi Public Health Association; and past member of the Governing Council, American Public Health Association.

Forrest General Hospital Plans Gastroenterology Seminar

A postgraduate course, "Advances in Gastroenterology," will be sponsored by the Forrest General Hospital in Hattiesburg on Nov. 6.

The program will feature a discussion of gastroenterology topics of interest to primary care physicians. Speakers are Dr. Jack Welsh of the University of Oklahoma Medical Center and Dr. James L. Achord of UMC's Division of Digestive Diseases.

For more information, contact the Department of Continuing Medical Education, Hattiesburg Clinic, P.A., 415 S. 28th Ave., Hattiesburg, MS 39401.

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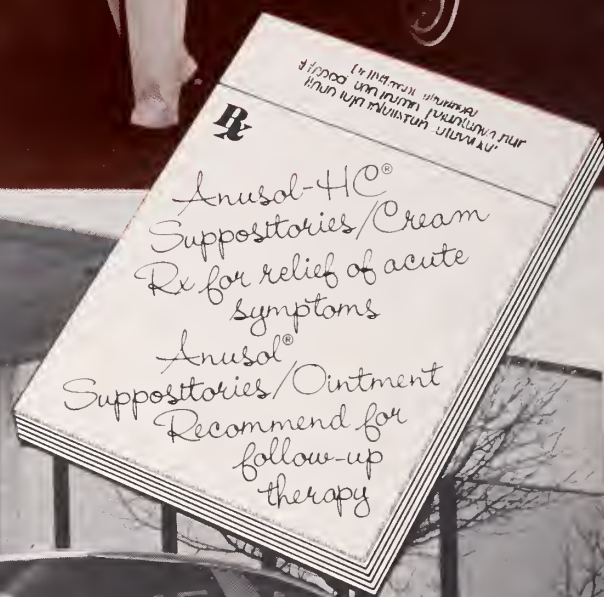
SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

IT WAS
NUMBER ONE
IN 1959

AND IT STILL IS...

The professional source of
modern anorectal comfort



ANUSOL-HC[®] SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC[®] CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C). Full information is available on request.

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NEWSLETTER

August 1980

Dear Doctor:

The AMA, in testimony before the Democratic Party Platform Committee, urged that more federal efforts be directed toward support of the private sector in order to strengthen the quality and accessibility of medical care for all Americans. Requests included continued support for medical manpower and health care facility development, increased research in the basic medical sciences, and special efforts in health education.

The AMA also urged that the platform include a strong statement urging the elimination of unnecessary federal regulation in medicine. Calling for reforms in the current regulatory process and for more public accountability by federal agencies, the AMA said regulations attempting to dictate physician medical judgement must be avoided.

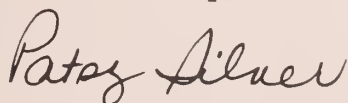
The Democratic Platform Committee was also asked to recognize the Voluntary Effort initiated by various private sector parties as the most effective and appropriate means of meeting hospital cost issues. The committee was urged to emphasize support to private sector efforts to improve health insurance coverage and protection, especially against catastrophic illness.

The Senate Human Resources Committee approved an amendment to the Medical Manpower Bill which provides that students at schools of chiropractic would be eligible for federal loans. Nine health organizations, including the AMA, opposed the amendment, which passed with no debate and no dissent. The organizations deplored the lack of public hearings and investigation.

A budget resolution reported by the Senate Finance Committee would deny free choice to Medicaid patients, AMA EVP James H. Sammons, M. D., told Sen. Russell B. Long. A section of the resolution authorizing states to limit access to care to certain hospitals and other providers as a means of reducing Medicaid costs would "create a two-tiered system of providing care," he said.

Federal funds will be provided to keep open two Harlem hospitals which had been slated for shutdown. Under the agreement the federal government will spend \$7.7 million to establish an HMO in Metropolitan Hospital and an unspecified amount to establish a specialized alcohol, drug abuse and mental illness program at Sydenham Hospital.

Sincerely,



Patsy Silver
Managing Editor

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1960s
1970s
1980s

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Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

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A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. — *The Editors.*

In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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DATELINE

Mental Institutions Under Study Jackson, MS - A two-year study of state mental institutions was begun last month. The ten-member committee, headed by Dr. Gerald Hopkins of Oxford, began the study with a review of the Mississippi State Hospital at Whitfield, which has been the target of recent criticism. An aide to Governor Winter has been instructed to investigate the charges by four black ministers that buildings were unclean and that some patients were mistreated.

Infant Mortality Data Gathered Columbus, MS - The Center for Disease Control in Atlanta will analyze data gathered this summer by American Medical Students Association members participating in a nationwide study of infant mortality. Focus will be on Noxubee, Lowndes, Lee and Monroe counties, where the infant mortality rate is higher than the national average. Funding of the project is through the Appalachian Regional Commission and the Tennessee Valley Authority.

HMO Seminar Is Scheduled Jackson, MS - Nationally known experts on HMOs will be featured on the program of an informational seminar on HMOs, to be held September 6 at the Jackson Sheraton Motel. MSMA is co-sponsoring the session with Central Medical Society. Reservations are offered on a first come, first serve basis. The registration fee - \$50 for MSMA members and \$70 for non-members - includes the seminar fee, program materials, coffee break and lunch.

Discounts Available From Avis Jackson, MS - MSMA members may receive a special discount from Avis Rent A Car System. There is a 20% discount on normal time and mileage rates in the U.S., and other discounts are available on foreign rates. Reference may be made at the time of rental to the MSMA Incremental Discount (AID) No. A/A776700. For information on receiving an Avis identification card, please contact Don Terry, District Sales Representative, 2024 Canal St., New Orleans, LA 70112.

Disposable Needles May Be Reused Chicago, IL - A yearly savings of almost \$78 million could be realized if all of the two million insulin-dependent diabetics in the U.S. were to use each disposable syringe-needle unit three times instead of one, and multiple use of the units appears to be safe, as well, says a report in the July 18 JAMA. Dr. Robert H. Hodge of the University of Virginia School of Medicine reported no infection was observed in a study of multiple use of the alcohol-cleansed needles.

AMA Publishes Update To CPT-4

Over 150 revisions are included in the Fourth Update to the Fourth Edition of the Physicians' *Current Procedural Terminology*, the American Medical Association's comprehensive system for naming, coding, and reporting medical procedures and services.

The summer 1980 Update to CPT-4 includes the following changes:

- Otolaryngology surgical and medical procedures have been extensively revised.
- New gastroenterologic procedures include gastric bypass and gastric stapling.
- Percutaneous transluminal angioplasty, subtraction studies, pelvic and extremity ultrasound, and abdominal aortography procedures are new radiologic services.
- Pneumococcus immunization has been added.
- Other newly coded procedures include newborn resuscitation, myocutaneous graft and free flap graft, repair of iris by suture, therapeutic drug monitoring, and several endocrinology and other laboratory tests.

The fourth update is being sent this month to individuals who have completed and returned the prepaid card included in the CPT-4 book.

CPT-4 was developed by and for physicians in response to the need for a uniform language that will accurately designate medical, surgical, and diagnostic services, thereby providing an effective means for reliable, nationwide communications among physicians, patients, and third parties.

CPT-4 is available through the Order Department OP-41, American Medical Association, P.O. Box 821, Monroe, WI 53566. Single copies of CPT-4 are \$12.00 each, orders should be prepaid; expect three to four weeks for delivery.

Academy of Pediatrics Adopts Health Goals

The American Academy of Pediatrics has adopted ten National Child Health Goals and published them in a booklet entitled "An Agenda for America's Children," in recognition of the Academy's 50 years of advocacy of children's health.

Through support of chapters at the state and local levels, the Academy hopes to increase public awareness of the serious health problems confronting our nation's children.

The following national goals have been selected by the Academy as action initiatives throughout 1980 and for the future.

- All children should be wanted and born to healthy mothers.
- All children should be born well.
- All children should be immunized against the preventable infectious diseases for which there are recommended immunization procedures.
- All children should have good nutrition.
- All children should be educated about health and health care systems.
- All children should live in a safe environment.
- All children with chronic handicaps should be able to function at their optimal level.
- All children should live in a family setting with an adequate income to provide basic needs to insure physical, mental and intellectual health.
- All children should live in an environment that is as free as possible from contaminants.
- All adolescents and young people should live in a societal setting that recognizes their special health, personal and social needs.

The 22,000 member American Academy of Pediatrics is the Pan-American association of physicians certified in the care of infants, children and adolescents.

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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] ^C

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlori-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and re-institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in one tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic en-

tagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as local or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardialopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vesopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Public Health Administrators Outline Preventive Health Needs



State Health Officer Alton B. Cobb, center, discussed public health planning and administration with Dr. George A. Reich, Region IV health administrator, and Dr. W. Grady Stumbo, secretary of the Kentucky Department for Human Resources. Dr. Reich, left, hosted the Region IV Public Health/Mental Health Officials meeting at Biloxi, where Dr. Stumbo was keynote speaker. Meeting participants agreed that cost-effective measures must be taken in preventive health practices to insure improved health status for people in the Southeastern region.

Future of Public Health Discussed at Coast Meeting

"Eradicate traditional public health?" asked Dr. W. Grady Stumbo, secretary of the Kentucky Department for Human Resources. "No, I've got a new dream."

Dr. Stumbo detailed his dream as keynote speaker at the May 14-15 Region IV Public Health/Mental Health Officials 36th annual meeting at Biloxi. Dr. George A. Reich, Region IV health administrator, hosted the meeting on the Coast.

Public health must move in the direction of primary care, he said. Local communities must begin and do health care services to improve the health status of their people.

Health officers from Alabama, Florida, Georgia, North and South Carolina, and Tennessee joined Mississippi State Health Officer Alton B. Cobb in discussing financial problems that plague the provision of services.

"The revised health budget for fiscal year 1981 that President Carter has submitted to Congress would have significant impact on public health services in Mississippi," Dr. Cobb reported. "The recommendation having the most significant impact is the total elimination of the Health Incentive Formula Grant Funds, formerly called 314'd' funds."

Dr. Cobb said the proposed cut would "severely limit activities in many of our most important and necessary programs: public health laboratory services, milk and shellfish services, environmental health services at our district and county health department level, and services in tuberculosis control."

Mississippi is not alone in the budget crunch. Each state representative reported increased needs and less money to meet those public health needs. National and regional-level speakers addressed the needs.

"The difficulties we face in public health in the next two years will mirror the past two," commented Dr. Ed Martin of the Bureau of Community Health Services in Washington. We've identified the problems and are now trying to take advantage of that information to reach solutions."

"The individual has a tremendous responsibility and decision-making opportunity that affects his health status," said Center for Disease Control official Dr. J. Don Millar.

"We in public health must educate people to help us meet ambitious disease prevention and health promotion incentives," he said.

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ORIGINAL PAPERS

Profile of the Renal Colic Patient

J. P. ELLIOTT, M.D., J. W. EVANS, M.D., J. O. GORDON, M.D., and
L. O. PLATT, M.D.

Tupelo, Mississippi

THE SIXTEENTH CENTURY AUTHOR Montaigne was a chronic stone former. In 1897, Sir William Osler quoted Montaigne's description of ureteral colic.¹ "Thou art seen to sweat with pain, to look pale and red, to tremble, to vomit well nigh to blood, to suffer strange contortions and convulsions, by starts to let tears drop from thine eyes, to urine thick, black and frightful water, or to have it suppressed by some sharp and craggy stone, that cruelly pricks and tears thee." In the intervening 400 years, ureteral calculi may perhaps have changed; symptomatic colic, however, has not.

Between November 1, 1976 and October 31, 1977, there were 20,870 admissions to the North Mississippi Medical Center, a 550-bed community hospital in Tupelo. Four hundred thirteen patients with the primary diagnosis and 52 patients with the secondary diagnosis of urinary stone were admitted during the 12-month period. Of these stone patients, 255 were admitted with acute renal colic, meeting our criteria of the sudden onset of flank pain and hematuria.

A retrospective analysis of the 255 consecutive patients admitted with acute renal colic revealed a seasonal inclination of ureteral colic occurring in the hot months (see Figure 1). There was a 62% increase in admissions for ureteral colic during May through October (159) over November through April (96).

Patient ages varied from 3 to 86, but the peak years were ages 25-30 and 40-45 (see Figure 2).

Sex and race data revealed that the series was dominated by 188 white males, or 73% (see Figure 3). There were 60 white females (22.5%), 4 black females and 5 black males (3.5%). When this is compared to the percentage of blacks (15%) in our general hospital population, it reveals a low incidence of stones in the black population.

The authors report a study of two hundred fifty-five consecutive patients hospitalized with ureteral calculi. The profile that emerged of the typical ureteral colic patient in North Mississippi was that of a young or middle-aged white male whose clinical symptoms erupted when a calyceal or infundibular calculus, having exceeded the strength of its attachments, dropped into the ureter of its own weight. Minor trauma commonly preceded the onset of symptoms. Of those patients requiring hospitalization, 68% resolved with symptomatic treatment, 16.5% required extraction of the calculus by cystoscopic manipulation, and 15.5% required open surgery.

Crystallographic stone analysis was predominantly calcium oxalate with a surprise finding of no magnesium ammonium phosphate (struvite) ureteral calculi (see Figure 4). Stone analysis is as follows: cystine — one, apatite — four, uric acid — nine, calcium oxalate or combined with apatite — 129. The term apatite is used in this paper to denote any of the synonymous terms calcium phosphate, brushite, or hydroxyl apatite.

This study was conducted at the North Mississippi Medical Center, Tupelo, MS. Read at the annual meeting of the Southeastern Section of the American Urological Association, Memphis, TN, April 2, 1979.

Investigation of the hour of onset revealed that of 109 patients in whom ureteral colic could definitely be pinpointed as to hour, 67 (61%) occurred during the hours of sleep from 11:00 p.m. to 7:00 a.m. (see Figure 5). Thirty-three and one third percent would have been expected to occur during this eight-hour period. Forty-two (39%) occurred during the other 16 hours of the day when 66 $\frac{2}{3}$ % would have been expected. Only the charts of patients that definitely stated the time of onset of acute renal colic or indicated the length of time between onset and admission into the emergency department were utilized. However, the possibility of error does exist due to the retrospective nature of the study and the fact that the patients might be more likely to record a specific time, having been awakened from a sound sleep.

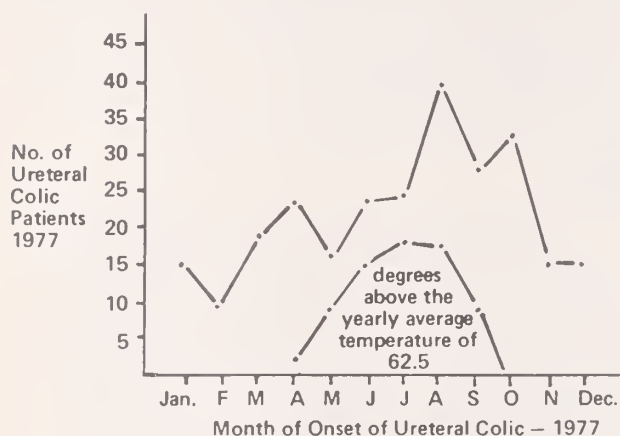


Figure 1

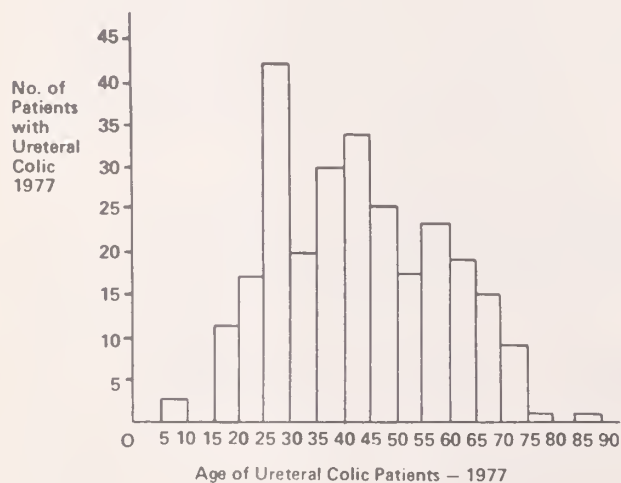


Figure 2

The method of therapy is illustrated in Figure 6. Sixty-eight percent of the patients either did not have stones or spontaneously passed their stones during or after hospitalization, 16.5% required stone manipulation, and 15.5% required ureterolithotomy for successful removal of their stones. Some of the ureterolithotomies were preceded by unsuccessful attempts at manipulation. Our success rate of stone manipulation during this study period was 85%.

No elevated serum calciums and no parathyroid adenomas were found in the cases of the ureteral colic, although two parathyroid adenomas were removed in our hospital during the study period.

There were no deaths in the series.

The seasonal incidence of ureteral calculi and the findings that they occur largely in the young and middle-aged white male forming predominantly calcium oxalate stones have been previously reported.^{2, 3}

The seasonal incidence of ureteral calculi would seem to incriminate dehydration resulting in increased concentrations of calcium and oxalate calyceal urine. Increased ingestion of oxalates may contribute to oxaluria.⁴ Oxalate-rich foods such as tea may augment oxaluria with ingested water in the tea leaving the body through the skin by perspiration. The resultant urine, small in volume, would be quite supersaturated with respect to calcium oxalate. The white male in our area certainly seems to follow this scenario. It would not be an unreasonable speculation, therefore, that white males in our area are at greater risk than other subjects of the population.

With regard to the age risk categories, no data are available that break down the general population into five-year brackets as was done with the ureteral colic patients. The 1970 census shows that 67% of the population was below age 45 and 33% was 45 or above. The inference can be made that there is a larger population at risk in the younger age groups, but no conclusion may be made from the data.

The methods of therapy are similar to other institutions with a reported heavy incidence of stone occurrence.⁵ We assume that most of the 49 patients who, upon IVP examination, were not found to have a stone, passed and lost the stone between the time of admission and the x-ray the following day. The results of the bowel prep and the distractions of severe renal colic sometimes supercede instructions on the use of urine strainers. All of these patients met the initial criteria of the sudden onset of flank pain and hematuria.

The fact that the onset of 61% of ureteral colic pain occurs during the eight hour sleep period (11:00 p.m. to 7:00 a.m.) would seem to indicate that a

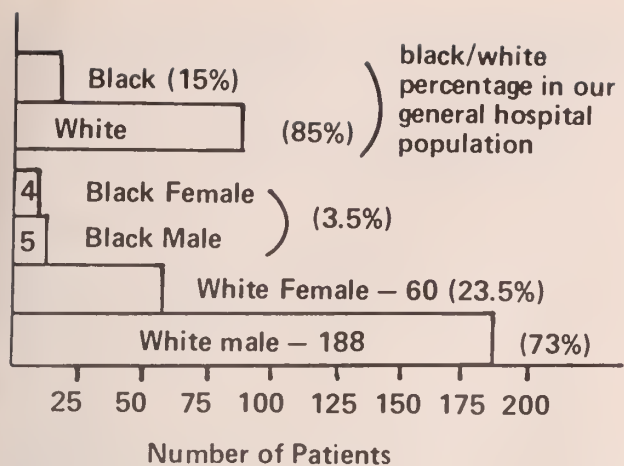


Figure 3

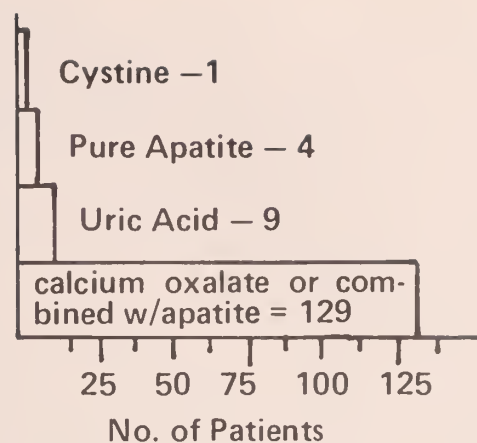


Figure 4

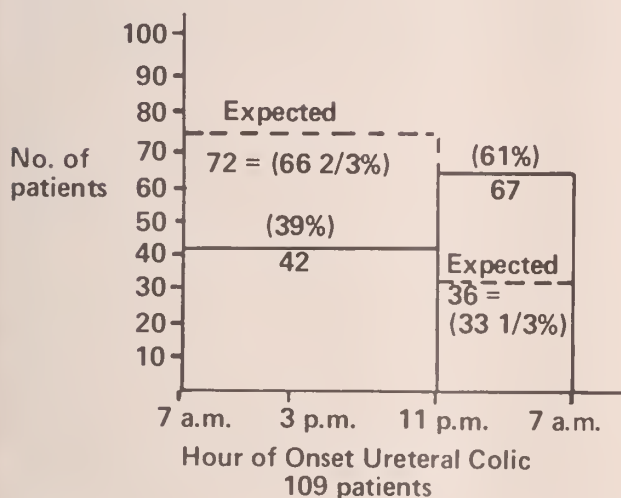


Figure 5

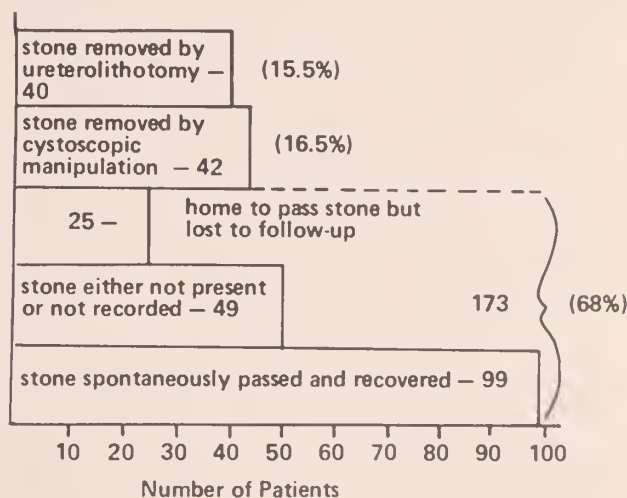


Figure 6

large percentage of stones tend to drop in response to gravity when the sleeping patient turns on his side, thereby positioning the kidney in the lateral position where most of the mid and lower calices are subjected to the full force of gravity for the first time during the day. This would seem to indicate that stones drop when their weight exceeds the strength of their attachments. One physician conducting this study has, on a number of occasions, witnessed ureteral colic occurring as a direct result of a shearing force such as a hunter firing a shotgun or a farmer riding rapidly across a plowed field in a pick-up truck. One patient underwent successful stone manipulation for seven small stones stacked in the lower ureter as the result of shooting a deer. The onset of colic occurred before the patient could walk 20 yards to his kill.

The fact that there were no magnesium ammonium phosphate ureteral calculi seems to indicate that these stones do not drop from the kidney until they are too large to pass through the ureteropelvic junction. This series is too small to pick up the occasional struvite stone that might pass, but previous analysis of our overall stone occurrence has revealed an occurrence of struvite stones at our institution of 9.5%. Coe reports an overall incidence of struvite stones as 21.5% in his lab whereas he found only 3% struvite stones that spontaneously passed.⁶

A personal communication from Dr. H. E. Hellwege of Lewis C. Herring & Company indicated that calcium oxalate calculi ($1.99-2.23 \text{ g/cm}^3$) are slightly heavier than magnesium ammonium phosphate calculi (1.71 g/cm^3).⁷ If there had been a marked difference in their densities, it might have resulted in

the smaller but heavier calcium oxalate stone breaking its attachments and dropping into the ureter at a smaller size. The difference was not large enough, however, to explain the complete absence of magnesium ammonium phosphate ureteral calculi.

Calcium oxalate stones probably form within the nephron and in the collecting duct where the duct enters the renal papilla, growing slowly by accretion to form a papillary stone.⁸ The struvite stone's genesis, however, is probably of a different nature. It would be a reasonable, although unproven, speculation that a gelatinous matrix of mucoprotein is formed in the collecting system in the presence of bacterial urease.⁹ This mucoid "oyster" in itself is usually too large to traverse the ureteropelvic junction. It rapidly mineralizes to become a struvite stone which is also too large to enter the ureter. ★★★

605 Garfield Street (38801)

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Radiologic Seminar CCV: CT in Intracranial Abscess

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WILLIAM F. RUSSELL, IV, M.D.

Jackson, Mississippi

CEREBRAL ABSCESS and the related counterpart, subdural empyema, represent severe threats of serious neurologic damage or death. Early diagnosis and initiation of appropriate treatment are required to prevent loss of cerebral substance and complications due to intracranial mass effect.¹ Surgical intervention, along with high dose antibiotics, has been the mainstay of treatment of formed abscesses. Accurate identification and localization of the abscess capsule and demonstration of multiple loculations and multiplicity of lesions, if present, are the responsibilities of the radiologist. Computed tomography (CT) is currently the modality of choice to meet the requirements for treatment. It affords a safe, simple means of diagnosis, treatment planning and follow-up. This article will illustrate the CT scan findings in several patients with intracranial abscess, and discuss the usefulness and advantages of CT as the investigation of choice in the management of these patients.

Intracranial suppurative infections, regardless of source, often result in encapsulated abscesses.² Concomitant increase in intracranial pressure is life threatening. Mortality has been high in most series reported before CT became available, ranging from 36% to 53%.³ Moreover, there has been an increase in the incidence of intracranial abscess.⁴ Common causes and predisposing circumstances associated with development of intracranial abscess include trauma, otolaryngologic infection, congenital heart disease, prior meningitis or encephalitis, septicemia and prior surgery; in many cases the source is not discovered.^{3, 5, 6} Most of these infections occur in supratentorial sites, with the frontal and parietal lobes most often involved.⁶ Both cerebral abscess and subdural empyema can be uni-, bi-, or multilocular, and solitary or multiple. Organisms found vary in different series, with common agents being

the pyogenic cocci and the gram negative enteric bacteria, although some increase in incidence of anaerobic and fungal organisms has been noted.³

The clinical presentation often includes headaches, focal brain disturbances, seizures and fever; also frequent are emesis, signs of meningeal irritation and lethargy. Laboratory findings characteristically include peripheral leukocytosis, and, in the cerebrospinal fluid, elevated protein, decreased glucose and elevated white cell count. Abscesses may, not uncommonly, remain unnoticed clinically, or findings may not be directive to infection, as when patients present without fever. Despite provisional clinical diagnosis, supplementary investigations are required for traditional surgical intervention.⁶

Complications of intracranial abscess include herniation of brain substance due to increased intracranial pressure, secondary infarction and hydrocephalus.⁷ Rupture into the ventricular system heralds a poor prognosis and is a particularly serious complication.⁴

Before CT, angiography was the preferred diagnostic method. Avascular mass displacements are commonly seen but demonstration of the pathognomonic abscess membrane by arteriography is not usual.⁴ The amount of the mass effect due to the abscess pocket itself can not be distinguished from the component due to the surrounding edema almost always present.⁵ The abscess membrane, when present angiographically, is usually not shown for several days after the CT demonstration is first possible.⁴ Angiography is useful in differentiating progressive stroke from cerebritis, and may show tumor vessels for distinguishing neoplasm from abscess. This differentiation is often needed because of the non-specific nature of the CT "ring" lesion.

Radioisotope brain scanning is a sensitive detector of most intracranial abscesses regardless of their size, but is ineffective in evaluating the posterior fossa.^{3, 8} Craniotomy sites usually show increased uptake of the scanning agent, obscuring detection of

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Figure 1. This is a typical, but not pathognomonic, example of a "ring sign" in a patient with brain abscess. Note the thin, uniform rim of contrast enhancement characteristic of the abscess capsule. Surrounding low density representing edema is also well demonstrated. Streptococcus cultured from surgical aspiration specimen.



Figure 2. Same patient as Figure 1, progress study. This scan shows partial regression of the abscess three months after surgical drainage and initiation of appropriate antibiotic coverage. Despite scan or clinical evidence of healing, recurrence of abscess can not be excluded unless follow-up scans are obtained until no enhancement is demonstrated.

underlying disease.³ Even when positive, the brain scan does not provide specific identification of the abnormality detected, nor can it reveal the amount of associated edema or the "maturity" of the abscess focus to direct drainage at the appropriate time and site.^{8, 9} Cerebritis cannot be differentiated from an encapsulated lesion; however, during the early cerebritis stage of intracranial suppuration, CT scanning may be insensitive, and radionuclide brain scanning may complement CT in the formative period of an abscess.⁸

Plain radiographs can provide important ancillary findings relating to the underlying cause of the infection, as sinusitis, mastoiditis or skull fracture. Plain films are, however, insensitive for abscess, and do not provide information needed for surgical management or for safely monitoring medical treatment trials.^{6, 9}

Ventriculography, pneumoencephalography and electroencephalography have been of some use, but have limited application because of invasiveness, non-specificity or insensitivity.^{4, 6}

Computed tomography is the preferred diagnostic method.^{4, 9} The characteristic finding on CT scans in brain abscess is a low-density mass, which shows a smooth, thin rim of increased density on the contrast-enhanced studies (see figure 1). A moderate amount of edema usually surrounds this ring of contrast enhancement.^{1, 4, 5, 6, 9} Only rarely is a rim not shown after contrast enhancement, and these cases usually represent either a small or immature abscess (see figure 3), an abscess which has ruptured into the ventricular system and thus decompressed itself, or an abscess which is scanned after corticosteroid or antibiotic treatment has been started.^{1, 6, 8, 9} The abscess capsule is a result of host-organism interaction, and comprises an inner layer of granulation tissue, a middle layer of collagen, and an outer layer of reactive glial cells.⁹ Cause of the rim enhancement of the abscess membrane is not completely understood, but probably relates to extravasation of circulating contrast medium as a result of a defective blood brain barrier, or to displaced cerebral vessels.^{4, 7} The demonstration of the abscess membrane permits assessment of the size, shape and position of the abscess itself, distinct from the surrounding edema commonly present. Multiple lesions, occurring in 5%-30% of cases, can be demonstrated (see figures 3 and 4).⁵ The use of contrast is mandatory for this evaluation, and routine contrast use greatly increases the detection rate, specificity and descriptive information obtained from the study.^{4, 8, 9} Occasionally, its use unables the detec-

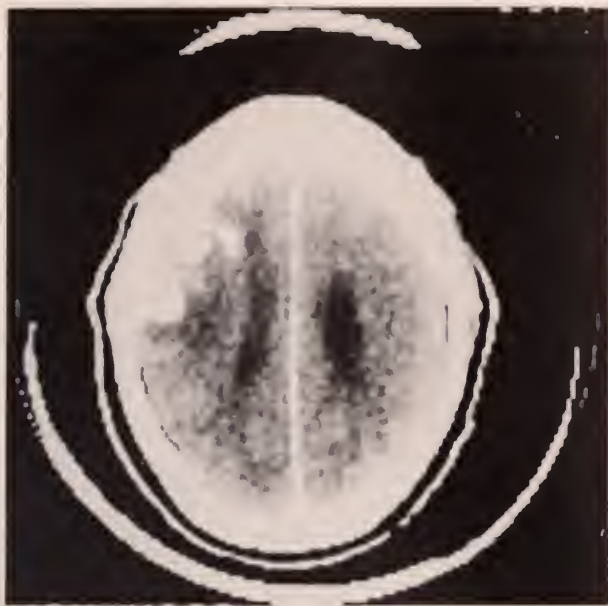


Figure 3. Multiple small immature abscesses are demonstrated; streptococcal origin. Note that such lesions appear solid, lacking the necrotic centers of their larger counterparts. This patient also had many other lesions seen on the lower level sections.

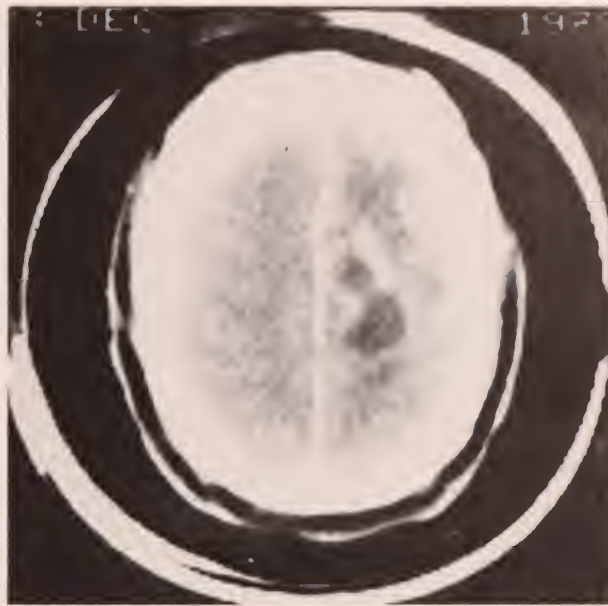


Figure 4. This patient had a multilocular abscess with variable wall thickness. This case demonstrates the variability of appearance of abscess on CT scans. Such multilocular lesions may be difficult to distinguish from malignant cerebral neoplasms by scan pattern alone.

tion of previously unsuspected lesions, such as basilar arachnoiditis or ventriculitis.^{4, 7}

Although the scan findings in abscess are typical, they are not specific. A similar appearance can be produced by necrotic primary neoplasms, metastases, resolving intracerebral hematomas and, rarely, infarcts. There is, then, a need for close clinical correlation, and sometimes for arteriography, to aid identification of CT lesions detected. False negative results are fortunately rare. The abscesses missed are often below the spatial resolution of the scanner (about 0.5 cm), or represent cerebritis not yet developed into a frank abscess cavity with surrounding membrane.^{1, 8}

Subdural empyema appears as a crescentic low-density extracerebral collection, with varying degrees of mass effect. After contrast administration, the typical membrane enhancement is seen bordering underlying cerebral cortex. The amount of associated cerebral edema is minimal with this entity.^{6, 9} Like cerebral abscess, these lesions are often multiple or loculated.⁶ The CT appearance can be closely simulated by chronic subdural hematoma, again emphasizing the need for consideration of all diagnostic information.

There has been a change in the mortality of this condition since the advent of CT. The use of CT has

lessened diagnostic difficulties and improved the therapeutic results, often dramatically.^{3, 4, 5, 9, 10} Following operative intervention, scanning contributes to improved outcome by allowing early detection of hematomas, brain swelling or other complications. Moreover, CT has made it possible to evaluate non-surgical approaches to the management of these patients. Earlier detection of cerebritis before actual abscess information permits antibiotic trials, which, if successful, obviate surgery.^{1, 3, 5, 9, 10} Computed tomography is the only study method that permits this differentiation of cerebritis from frank abscess.² With either surgical or medical management, recurrence of abscess should be excluded by obtaining serial progress scans until complete resolution has occurred (see figure 2).

Computed tomography is the neuroradiologic modality of choice in the diagnostic investigation, management and follow-up of patients with intracranial abscess. It provides early, highly sensitive diagnosis, precise localization and better differential diagnostic information than any other method of study. The appearance of a low-density intracranial mass, with characteristic rim enhancement after intravenous contrast administration, associated with a moderate amount of surrounding edema, is typical of abscess. Although this CT appearance is highly sug-

INTRACRANIAL ABSCESS / Pittman et al

gestive of abscess, it is not specific, and differentiation from primary and secondary neoplasms, resolving hematoma, and infarct usually depends on clinical supportive information as well as additional workup, especially arteriography. Computed tomography has allowed earlier, more successful treatment of patients with the serious problem on intracerebral abscess, and has permitted safe trials of non-conventional medical methods of treatment.

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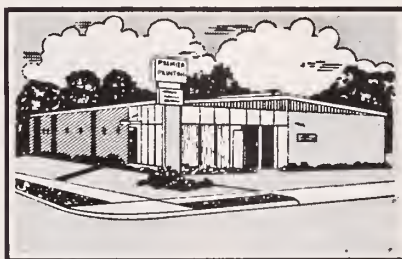
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Dr. Hallie Garrett: Corinth Physician

BEULAH M. D'OLIVE PRICE

Corinth, Mississippi

ONE OF MISSISSIPPI'S early woman physicians was Dr. Hallie Garrett. So far as is known Dr. Garrett was the first woman medical doctor to practice in the Corinth area.

Hallie Garrett was born April 9, 1874 at Pocahontas (Hardeman County) Tennessee. Her parents were Major George Washington Brooks Garrett and Elizabeth Jane (Bouton) Garrett. She attended the Iuka Normal Institute where she received the Master of Accounts degree. She had three years experience keeping books for the G. W. Garrett Mercantile Company at Pocahontas.

In 1900 Hallie Garrett obtained her A.B degree from Southwestern Baptist University (now Union University at Jackson, Tennessee). She studied "late and early" and during vacation and completed the course of study in three years. In the fall of 1900 Hallie entered the Woman's Medical College of Baltimore where she completed the three-year course of study in two years. The five years of overwork "completely prostrated her for 18 months."

In the fall of 1902 Hallie entered the Illinois Medical College at Chicago and took a reduced academic load so that she could rest a part of each day. By the third term she had caught up in her studies and had done some volunteer work at the Cook County clinics. Hallie obtained her M.D. degree in July 1904 and interned at Mary Thompson Hospital in Chicago until July 1905.

Dr. Garrett moved to Corinth, where her parents were then living, and opened an office. In two years she had established a good practice. Her office was over Bramlitt's Hardware store on the southeast corner of Cruise and Franklin Streets. (The building still stands and is presently occupied by Biggers Hardware.) Dr. Garrett used a horse and buggy for making calls and for county visits she took along a young black boy to look after the horse.

It was the custom among the Corinth doctors to take monthly turns in making calls to the County Home. The home was east of Corinth at Shelton's Hill on the Farmington Road. As the most recent doctor to enter practice locally, Dr. Garrett fell heir to the worst months of the year, weatherwise. She prepared by getting a pair of rubber boots. In mud, sleet or snow, she was ready. If the buggy wheels

mired down she draped her long skirt over one arm and proceeded on foot.

On September 19, 1907 Dr. Garrett was married at the home of her parents to the Rev. Charles L. Neal. A Kentucky native, Rev. Neal was at that time pastor at DeFuniak Springs, Florida. He had served in the Spanish American War. In December of 1907 the Neals left for Mexico as foreign mission appointees of the Southern Baptist Convention. Dr. Neal had volunteered for service as a medical missionary in March 1902 at a meeting of the Students Volunteer Movement in Toronto, Canada.

For most of their first two decades in Mexico the Neals were in Toluca, where Dr. Neal began her medical ministry and her husband taught in the Baptist schools there. During the Revolution she volunteered her service at the hospital which the Red Cross had opened at Toluca. The soldiers came to prefer her. They said her hands were gentle. There were many political upheavals during the Neal's ministry in Mexico. At times they were persecuted, fined and jailed. Dr. Neal's husband said of her, "She wasn't afraid of the devil." Dr. Neal worked through epidemics of influenza, smallpox, typhus, typhoid fever, scarlet fever and measles. She had a regular practice besides treating soldiers and charity patients.

In 1917 Dr. Neal was in Corinth, where she gave birth to a son. Unfortunately the infant died.

In 1942 the Neals retired from their ministry in Mexico and settled in San Antonio, where they worked with the Spanish speaking persons. Later Dr. Neal made her home in Corinth, where she died on February 9, 1964. Her husband had died the previous year.

P.O. Box 7 (38834)

Acknowledgment

Most of the information for this sketch was obtained from two of Dr. Hallie Garrett Neal's nieces, Mrs. Ben Everett of Memphis and Mrs. Dan B. Delp of Corinth, and a great-niece, Mrs. George Mercier of Corinth. Other sources were a log kept by Rev. C. L. Neal and notices in *The Daily Corinthian* and the *Baptist Record*.



The President Speaking

AMA Meeting — Opportunity for Solving Problems

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

Before these thoughts appear in the Journal, the AMA Annual Meeting in Chicago will be history. I have spent the past few days getting my thoughts together, trying to arrive at an opinion of just what I hope to accomplish at the Annual Meeting. A fine delegation from MSMA will travel to Chicago for a busy week. I can assure you that they will have the best interest of organized medicine as top priority.

It is of interest that the AMA meeting begins as the 1980 GOP Convention ends. The major topics of that Convention have been the economy and foreign policy. We certainly have not heard much about a large national health program. This makes good sense. How can you improve on the best health care program in the world? Along these same lines, I had the opportunity recently to attend the inauguration of officers of the Mississippi Academy of Family Physicians. The primary message of the keynote speaker was service to our patients and ways we can improve health care. These are thoughts that all should have. We should get politics out of medicine. The only way to accomplish this is to just make it so good that everyone wants it.

We have had, and still have, those individuals or groups that would like to give this country away, not necessarily to some foreign power, but to certain other groups among us. It never hurts to give anything to anyone if there is a need or if someone deserves it; but giving something for nothing will almost always destroy anything. We have those who advocate sharing the wealth, but those who have these thoughts and those who would be the recipients do not care to share the work or responsibility. Some say, with tongue in cheek, that wealth would have to be divided every Friday because the doers or hustlers would have it back by Monday. There is some truth to this.

With American medicine in the spotlight today, we should work very hard to get the good news out. We should not be bashful in telling our story. We should inform the people how good we are. They already know that health care is good, but is also expensive. We should not be ashamed to justify the cost of health care. I think that we can. Of course we would like to see the cost of medical care stay affordable to the masses; in fact, it must. I believe that private health insurance is one of the few bargains left today. People should compare what they get from this with what they get from certain other programs. For sure, not too much time will have to be spent in convincing people that we do not need socialized medicine. This is not to say that we do not need to know what goes on in government programs. Every time a government health program comes into existence, the cost of medicine goes up and we lose a little control as to who knows best about the health care of this country.

The meeting in Chicago should afford us the opportunity to hear our colleagues from different parts of the country tell us their problems as they hear ours. We will likely hear some answers to solving these problems. We expect to hear how to make medicine better, how to get the service to the people, how to get the people to us to receive our services. We hope and believe that this will be one of the best meetings the AMA has had.

★★★

EDITORIALS

Spotlight on HMO Issue At MSMA Conference

The HMO issue, a much discussed and debated subject, currently occupies the spotlight in medical socioeconomic events.

In an attempt to enlighten the membership and other interested parties, the leadership of your association has planned an interesting and diverse program regarding the HMO concept. All members are urged to attend this conference, to be held in Jackson on Sept. 6, and become better informed about a subject that appears destined to involve all of us in one way or another in the near future. You are also urged to invite as your guests other interested parties — industrial, civic, and hospital leaders — so they may also become better informed.

In offering this conference the association takes no official position supporting or rejecting HMO's. The program is presented as a resource conference, with representatives from reportedly successful and unsuccessful HMO's explaining the concepts, objectives, accomplishments, and failures noted in current programs.

Additional information will be published regarding registration. Please avail yourself of this opportunity.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, MS

LETTERS

SIRS: This is a request for your assistance in helping General Motors retirees and surviving spouses submit their health care claims and to help us pay claims promptly.

Metropolitan Life Insurance Company is the health care insurance carrier for a large number of General Motors retirees, surviving spouses and their dependents. Through an arrangement with the government and the carriers handling Medicare Part B, Metropolitan has developed a special claims processing system for General Motors retirees and surviv-

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 8

AUGUST 1980

ing spouses. Retirees and surviving spouses enrolled in the "General Motors Retiree Health Care Servicing Program" have been issued a distinctive identification card.

Under this servicing program you, the physician or other provider, file all claims directly with Metropolitan, using Metropolitan and/or your standard billing forms. Metropolitan will promptly pay you the reasonable and customary fee for covered services rendered. There are no deductibles and no copayments involved (with the exception of outpatient psychiatric services).

Following our payment to you, Metropolitan will seek reimbursement from the Medicare carrier. Any services not covered by Metropolitan will be forwarded to the Medicare carrier for processing.

The advantages of this system to you is the prompt payment of claims by Metropolitan without the need to submit claims to Medicare. The advantage to your patient is the payment of the full scope and level of General Motors Health Care Coverage without the need to suffer out-of-pocket expenses while waiting for reimbursement from Medicare. We urge you not to file with both Medicare and Metropolitan since this could result in delay and possible duplicate payment which would have to be repaid.

Metropolitan has a toll-free telephone line to be used exclusively for inquiries relating to claims and service for retirees and surviving spouses. Should you have any questions, please feel free to call our claims office (800-241-9964).

PAUL S. ENTMACHER, M.D.
Vice President and Chief
Medical Director
Metropolitan Life Insurance Co.
New York, NY

HMO Informational Seminar
Jackson Sheraton Motel
Saturday, September 6, 1980
Plan Now to Attend

How Long Should You Keep Medical Records?

One of the most frequent questions doctors and their office personnel ask is "How long do I have to keep my medical records?"

There is no set and simple answer to this question. However, a look at Mississippi's statute of limitations for injuries resulting from medical malpractice does give some guidelines as to an advisable length of time.

Mississippi's current statute of limitations is two years from the date of discovery. In other words, if a sponge is left in a person during surgery, and the patient does not discover the presence of the sponge until ten years later, that person has two years from the date he discovered the sponge in which to sue. Therefore, it is difficult to set a specific number of years that records should be kept.

Another problem in determining the length of time for keeping records comes with the treatment of minors. Minors have two years from the date they attain majority in which to sue. Therefore, even if discovery of the injury was made at age 12, the patient would have until age 23 to sue.

Adding to the confusion is the fact that in the case

of a death for which the doctor might be sued, the statute of limitations is six years.

Therefore, in order to be properly protected (i.e. having the patient's records in the event of a suit), disposal of patient records should take place in the following order:

1. Records of those patients who have been dead for longer than six years;
2. Records of those patients who have not been treated for the longest period of time and who were adults at the time of treatment;
3. Records of patients who were minors at the time of treatment and who have passed the age of 23;
4. Records of any patient who appeared dissatisfied or hostile or who was able to pay the bill and did not.

It should be noted that there is still a chance that a physician might be sued and not have the patient's medical record. However, if the order of disposal described above is followed, those chances are minimized. If at all possible, it is in the best interest of the physician to keep records indefinitely.

—B.C.M.

Medico-Legal Brief

Chiropractor Liable For \$200,000 In Damages

A chiropractor was liable for \$200,000 in damages for negligence in treating a patient for a work-related injury, an Illinois appellate court ruled.

The patient had an operation on a ruptured disc in the lower lumbar region of his back in 1968. He returned to work after the operation and had no further back problems until September 1973. On about September 25, 1973, he slipped on some grease at work and felt a sensation in his back "like glass breaking in a rag." After treatment in a hospital, he saw a chiropractor for pain. Between October 5th and October 22nd the patient saw the chiropractor six times. The chiropractor observed the scar on the patient's back from the earlier operation and performed adjustments on two occasions.

After the adjustments, the patient's pain was

worse. Just after his visit on October 15th, the patient noticed that his right leg and foot went completely numb. The chiropractor advised him, as he had done several times earlier, that it would improve in time. On October 24th the patient consulted a neurosurgeon, who ordered him hospitalized. After performing a myelogram, the surgeon operated to remove a ruptured disc. The operation relieved his pain but did not improve the numbness in his leg.

In a malpractice suit against the chiropractor, a jury returned a verdict of \$200,000. On appeal the appellate court affirmed the decision. An expert witness chiropractor testified that the patient's case was not one for chiropractic services. The neurosurgeon testified that the chiropractor's manipulation of October 15 caused the nucleus pulposus to extrude. The evidence supported a finding that the chiropractor had violated the standard of care for chiropractors, the court concluded. — *Chamness v. Odum*, 399 N.E.2d 238 (Ill.App.Ct., Dec. 27, 1979)

MEDICAL ORGANIZATION

MSMA Jail Health Project Conducts Mental Health Course

Professionals in the fields of mental health and jail administration met at a recent workshop sponsored by MSMA's Jail Health Care Project.

"The primary purpose was to bring the two groups together to discuss problems and determine the best methods in meeting the court-mandated duty for jails to provide mental health care for inmates," said Dr. Virginia Tolbert of Parchman, chairman of MSMA's Jail Health Care Advisory Committee.

Leading the forty-two registrants in a discussion of the legal issues was Carole Morgan of Boulder, CO, director of the Mental Health in Jails Project for Training Associates, Inc. Providing information to jail staff members on the recognition and management of mentally disturbed inmates was Mike Haley of Linden, AL, a psychologist on the staff of the West Alabama Mental Health Center and coordinator of criminal justice services in Marengo County, AL.

The workshop leaders, both consultants with the National Institute of Corrections, guided the registrants through a series of exercises designed to clarify roles of the two groups, promote understanding of each group's problems in delivering mental health services to inmates, and establish goals for implementing appropriate services.

Also addressing the group were Anne Robertson,

director of the Division of Alcohol and Drug Abuse, Mississippi department of Mental Health, and Vick Robbins, criminal justice liaison for the Gulf Coast Mental Health Center and the Harrison County Sheriff's Office.

Twelve Mississippi jails are currently enrolled in MSMA's program, which is under the direction of Ella Tardy of Jackson.

Atkinson Lecture Series Conducted at KDH

"Recent Advances in Diagnosis and Treatment of Neoplasms" was the topic of the first course of the annual Jack A. Atkinson memorial Lecture Series conducted recently at King's Daughters Hospital in Brookhaven.

Physicians from Brookhaven, Meadville, McComb, Tylertown, Hazlehurst, Wesson, Monticello, Crystal Springs and Magnolia attended the seminar, which was designed to cover the aspects of treatment and diagnosis of neoplasms as viewed from five specialty areas.

Guest speakers included Dr. J. Tate Thigpen, director of the Division of Oncology, Department of Internal Medicine, University Medical Center; Dr. Harvey Johnston, clinical professor of surgery at UMC; Dr. Kenneth G. Carter, member of the Radiological Group at Mississippi Baptist Medical



Officers installed during MSMA Auxiliary's 57th Annual Session, from left, are Mrs. Stewart Williford, Hattiesburg, recording secretary; Mrs. Stanley Hartness, Kosciusko, second vice-president; Mrs. Curtis Roberts of Brandon, president; Mrs. John Estess, Hollandale, president-elect; Mrs. James Martin, Ocean Springs, first vice-president; Mrs. I. C. Knox, Jr., Vicksburg, third vice-president; Mrs. Ben Martin, Columbus, fourth vice-president; and Mrs. Joe Herrington, Natchez, treasurer.

center; and Dr. Richard C. Boronow, clinical professor of gynecology at University Medical Center.

The Continuing Medical Education Committee at King's Daughters Hospital sponsored the seminar. Dr. Braxter Irby is committee chairman.

Mrs. Marion Brown is president of the Medical Wives' Auxiliary, which planned activities for wives of the physicians attending the daylong session.

Medical Assistants Elect New State Officers

Mrs. Glenda Jenkins of Meridian was installed as president of the Mississippi Chapter of the American Association of Medical Assistants at the society's recent annual convention in Natchez.

Other officers are: Mrs. Myrtle Cain of Tupelo, vice-president; Mrs. Helen Donohoo of Gulfport, treasurer; Mrs. Gladys Lamb of Greenwood, secretary; and Miss Carol Locky of Pearl, president-elect.

Medical assistants from throughout Mississippi attended the three-day convention. The program featured several accredited workshops in addition to business meetings and social activities.

PHYSICIANS

One of America's largest health care corporations is currently seeking both a full and part-time Physician for our Plasma Donor Center located in Mississippi. Responsibilities will include performing physicals in conjunction with donor screening and evaluation. The part-time position would provide support when regular staff physicians are on vacation.

Our requirements are flexible and we will consider licensed but non-practicing physicians as well as those desiring to work on a consulting basis.

We offer excellent working environment and a highly competitive salary. For further information, please send curriculum vitae to:

Ad Tech, Inc.
17842 Irvine Blvd., Suite 118
Tustin, California 92680

Equal Opportunity Employer M/F

Dr. Rose Named President Of Heart Association

The vice speaker of MSMA's House of Delegates, Dr. Walter H. Rose of Indianola, has been elected president of the American Heart Association — Mississippi Affiliate.

A pioneer leader of the now statewide Cardiopulmonary Resuscitation Training Program, Dr. Rose has been active in all county, district and state program areas of the Heart Association. He is also past president of the Mississippi Academy of Family Physicians and the Delta Medical Society.



Dr. Rose

Dr. Rose has received the MSMA-Robins Award for Community Service and the Mississippi Magnolia Medal for outstanding service to the Mississippi National Guard.

The Indianola physician succeeds Preston H. Gough of Jackson as the leader of the voluntary health agency. Named to serve with Dr. Rose are: Jackson banker John P. Malone, president-elect; Jackson cardiologist Dr. Quinton H. Dickerson, vice-president; Hollandale community leader Jean Hill, secretary; Jackson banker William R. Boone, treasurer; and Jackson insurance executive William G. Shackelford, assistant treasurer.

MBMC Schedules Cardiovascular Seminar

Mississippi Baptist Medical Center will conduct a seminar on cardiovascular medicine and surgery at the Downtown Holiday Inn in Jackson, Sept. 19-20.

Guest speaker will be Dr. Michael E. DeBakey, Baylor College of Medicine, Houston, TX. Dr. DeBakey will speak on "Patterns of Atherosclerosis" and "Surgical Considerations of Coronary Disease, With Long-Term Results."

Also participating will be Drs. Thomas L. Kilgore, Jr., Martin H. McMullan, H. Davis Dear, and Michael Boland, all of MBMC, and Steve Hindman of University Medical Center.

For further information, contact Mrs. Jean May, Public Relations Office, MBMC, 1225 North State St., Jackson, MS 39202 or call (601) 968-5135.

PERSONALS

O. J. ANDY of UMC presented a paper at a June meeting of the American Society for Stereotactic and Functional Neurosurgery in Houston, TX.

BRUCE E. ATKINSON of Amory and LODOVICO BALDUCCI of Jackson have been made Fellows of the American College of Physicians.

GEORGE BALL, KENNETH P. PITTMAN, C. JAMES LEWIS, JR., and FRANK R. BANKS of Jackson announce the association of WILLIAM E. BECKMAN, III, for the practice of obstetrics and gynecology.

DONALD H. BUTTS of Jackson announces the opening of his office for the practice of neurology at 1815 Hospital Drive, Suite 262.

DAVID V. CARNER has opened his office for the practice of general and vascular surgery at 439 North Jackson Street in Brookhaven.

A. W. CONERLY of UMC was guest speaker at a June medical staff meeting at the Charleston Hospital.

FRANK COVINGTON, JR., of Jackson announces the opening of his office for the practice of psychiatry at Suite 102, 1765-A Lelia Drive.

EDGAR DRAPER of UMC was guest lecturer at the University of Cincinnati (Ohio) in June.

STEVEN B. FINEBURG of Pascagoula announces the relocation of his office to 2204 Old Mobile Highway.

JAMES HARDY of UMC recently presented a paper at a meeting of the International Surgical Group in Heidelberg, West Germany and delivered the Mayo Lecture at Chicago Northwestern University.

JAMES HUGHES spoke at a May meeting of the Corpus Christi Orthopedic Society in Corpus Christi, TX.

JOHN MARASCALCO of Greenville was guest speaker at a recent meeting of Mainstream Chapter of Medical Assistants.

JOHN C. MORRISON of UMC was visiting professor at Bowman Gray School of Medicine at Wake Forest University in June and was guest speaker at a recent meeting of the American College of Obstetricians and Gynecologists in Hodges Gardens, LA.

AUBREY N. NICHOLS announces the opening of his office for the practice of ophthalmology at 143 Howard Street in Centreville.

ROBERT A. SANFORD of UMC presented a paper at the Rehabilitation Institute of West Florida in Pensacola in June.

W. LAMAR WEEMS was one of 35 urologists in the country invited to participate in the American Urological Association education workshop in Chicago in June.

JAMES P. WOOD was recently appointed by Attorney General Bill Allain to a four-year term on the State Oil and Gas Board.

NEW MEMBERS

PURDY, JAMES J., Meridian. Born Hancock, MI, May 25, 1946; M.D., University of Michigan Medical School, Ann Arbor, 1971; interned USPHS, New Orleans, 1971-72; Ob-Gyn residency, same, 1972-75; elected by East Mississippi Medical Society.

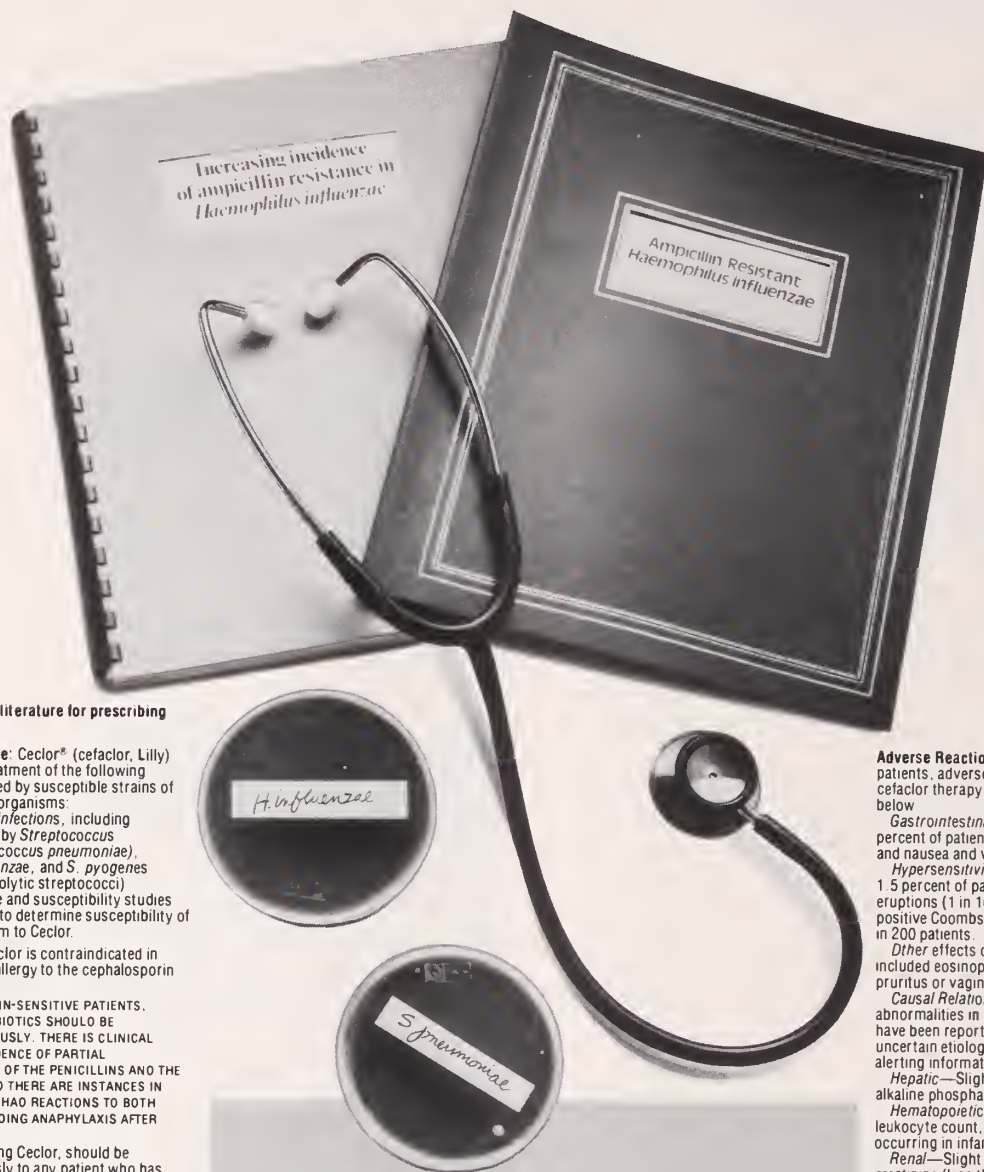
DEATHS

FORMAN, ROBERT L., Born New York City, NY, May 13, 1921; M.D., New York Medical College, New York City, 1945; interned Maimonides Hospital, Brooklyn, NY, 1945; radiology residency, City Hospital, Welfare Island Hospital and Bronx Veterans Hospital, New York City, 1946-48; Emeritus Retired member of MSMA and American Medical Association, died May 26, 1980, age 59.

HUDSON, J. MANNING, Jackson. Born Blue Mountain, MS, May 31, 1919, M.D., University of Pennsylvania School of Medicine, Philadelphia, 1943; interned Robert Packer Hospital, Sayre, PA, 1944; internal medicine residency, Philadelphia Hospital, Philadelphia, PA, 1947-50; died May 30, 1980, age 60.



An added complication... in the treatment of bacterial bronchitis*



Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS. CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefactor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefactor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 10) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.⁸

Note: Cefclor® (cefactor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8: 91, 1975.
2. Antimicrob. Agents Chemother., 11: 470, 1977.
3. Antimicrob. Agents Chemother., 13: 584, 1978.
4. Antimicrob. Agents Chemother., 12: 490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13: 861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630.



MEETINGS

National and Regional

American Medical Association Winter Scientific Meeting, January 12-15, 1980, San Antonio, TX; James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 1980, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 112th Annual Session, April 27, 1980, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638, Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday, each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Rodney Baine, Secy., 110 Yazoo Ave., Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. W. W. East, Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Paul Mink, Secy., 314 W. Adams St., Kosciusko 39090. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, March, August, December. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. Thomas Waller, Secy., P.O. Box 1487, Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. Robert D. Holbert, Secy., P.O. Box 1502, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Clyde Allen, Secy., 1245 N. 6th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the Director, Continuing Medical Education, at the individual institution or organization.

Council on Scientific Assembly
Mississippi State Medical Association
735 Riverside Drive
Jackson, MS 39216

North Mississippi Medical Center
830 Gloster Avenue
Tupelo, MS 38801

Forrest General Hospital
Box 1897
Hattiesburg, MS 39401

Mississippi Baptist Hospital
1225 N. State Street
Jackson, MS 39201

Gulf Coast Community/Gulfport
Memorial Hospital Consortium
4642 W. Beach Boulevard
Biloxi, MS 39531

Jefferson Davis Memorial Hospital
Box 1488
Natchez, MS 39120

King's Daughter Hospital
Box 948
Brookhaven, MS 39601

Delta Medical Center
Greenville, MS 38701

Riverside Hospital
Lakeland Drive
Jackson, MS 39208

Mississippi Radiological Society
316 Medical Arts Building
Jackson, MS 39201

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614

Mississippi Chapter
American College of Surgeons
Box 5229
Jackson, MS 39216

Mercy Regional Medical Center
100 McAuley Drive
Vicksburg, MS 39180

St. Dominic-Jackson Memorial Hospital
Lakeland Drive
Jackson, MS 39216

North Panola County Hospital
Drawer 160
Sardis, MS 38666

Singing River Hospital
2809 Denny Avenue
Pascagoula, MS 39567

Magnolia Hospital
Alcorn Drive
Corinth, MS 38834

Greenwood Leflore Hospital
1508 Leflore Avenue
Greenwood, MS 38930

RECOLLECTIONS

"Medicine's greatest fault lies in its inability to anticipate the demands of the people far enough ahead . . . to effectively remove these demands from those political opportunists who do not fully understand them. It seems that we are always on the defensive." So wrote Dr. Thomas J. Marland, editor of Journal MSMA, in the August 1960 issue.

Dr. Marland's editorial criticized legislation establishing a program of federal/state medical care for the "near needy" which was expected to be enacted by Congress. He concluded, "There is probably one significant lesson to learn from recent trends in our governmental attitudes and policies . . . The people of this country will always get what they need or think they need, even if a principle has to be sacrificed. And this is the danger because as one relinquishes one ideal after another, we gradually find ourselves stripped of ideals, so that there is no longer anything to lose."

An article suggesting how physicians could "humanize" their waiting rooms to suggest high standards of medical service, convey a message of competence and orderliness, and invite ease and relaxation was reprinted from a Pennsylvania Medical Society bulletin.

PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

PHYSICIANS WANTED TO RENT OR LEASE completely furnished 14-room modern clinic in county seat with population 15,000. New 36-bed hospital and 60-bed nursing home. Ill health caused physician to vacate clinic after 25 years successful practice. Call (601) 326-2741 between 8:00 a.m.-6:00 p.m.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available.

Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

BOARD ELIGIBLE OB-GYN concluding 4-year Ob-Gyn residency July 1 seeking solo, association or partnership position in semi-rural area of Southeast. Contact: James D. Long, M.D., 131 Beverly Ave., Norfolk, VA 23505.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

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Index to Advertisers

Alpha Therapeutics	176
Avis Rent A Car System	17
Boeringer Ingelheim, Ltd.	6B, 6C, 6D
Canton Exchange Bank	16
Citizens Bank	7
Darkroom, Inc.	14
Harreld Chevrolet	19
Eli Lilly and Company	178
Merrell-National, Inc.	6, 6A

Miss. Medical Fraternal and Educational Society	15
Northwestern Mutual Life	12
Parke, Davis	8
Premier Printing	170
Riverside Hospital	4
Roche Laboratories	second, third and fourth covers, 3
U. S. Air Force	18
Wyeth Laboratories	14A, 14B
Thomas Yates and Co.	10

IN CONCLUSION

The Mississippi State Board of Health urges physicians to consult with them about persons with undiagnosed febrile illness who have recently returned from foreign countries, especially Africa. Recently "discovered" diseases such as Lassa fever, Marburg virus disease and African hemorrhagic fever pose special problems because their clinical and epidemiologic patterns are not well established and the risk to U.S. residents is unknown. SBH will assist in diagnostic evaluation and, if indicated, quarantine and surveillance.

The Department of HHS is sending a free catalog of comparative price information on prescription drugs to 500,000 physicians and pharmacists. The 220-page catalog divides 184 of the most frequently prescribed drugs into 16 therapeutic categories. The guide lists the generic and trade name for each drug, the marketer of the drug, and the cost to the pharmacist for one day of therapy. Bar graphs show the daily therapy cost of each drug in comparison with other brands of the same drug.

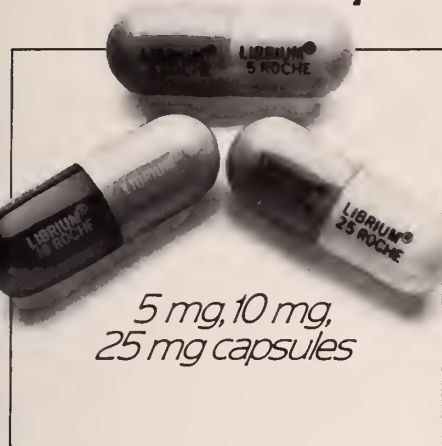
A team of scientists from The Upjohn Company and the Argonne National Laboratory reported in June that they have discovered an abnormal protein - indicative of a genetic defect - in cells from diabetic and prediabetic Chinese hamsters, but not in cells from nondiabetic hamsters. If a similar genetic marker can be found in man, said one researcher, early detection should allow early initiation of preventive or ameliorative measures. Analysis of liver cells by two-dimensional gel electrophoresis revealed the presence of the abnormal protein.

Abbott Laboratories Diagnostics Division received FDA approval for HAVAB-M, the first single test to specifically identify acute hepatitis A infection. The radioimmunoassay is said to enable physicians "to identify IgM antibody with a single test that is faster, more accurate and more economical than the existing methods which involve multiple tests... The results of the FDA's first-ever Public Board of Inquiry are expected soon. The PBOI is evaluating scientific evidence which may lead to reapproval of the artificial sweetener aspartame.

Time-Life Video is marketing a film series suggested for use in hospitals, community health organizations, nursing homes, public libraries, medical and nursing schools, and business and industry health education training programs. "Coping With Serious Illness" features actress Meryl Streep and deals with pain, doctor/patient relationships, sexuality, relationships and stress, finances, and facing death. Authorities in the areas of medicine, psychology, patients' rights, law and finance discuss problems of the seriously ill.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and

acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

*synonymous
with relief of anxiety*

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chlordiazepoxide HCl/Roche
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ROCHE

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with relief of anxiety*

Please see preceding page for a summary of product information

September 1980

BALCONY

JOURNAL of the **MISSISSIPPI** State Medical Association



Malpractice: Medicine in the Courtroom

half-life

Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued.

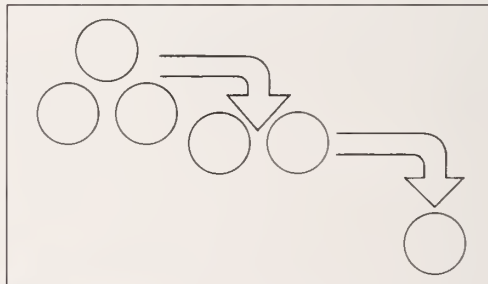
Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*

Before prescribing, please see summary of product information on next page



Valium® diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

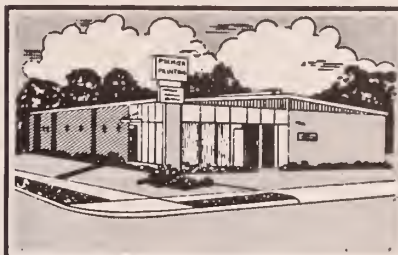
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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ANUSOL-HC[®] CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, incomplete fistulas and relief of local pain and discomfort following anorectal surgery. Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C). Full information is available on request.

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JOURNAL of the **MISSISSIPPI** State Medical Association



September 1980, Volume XXI, Number 9

ORIGINAL PAPERS

- 181** Prolonged Remission of Metastatic Rhabdomyosarcoma: the Use of Chemotherapy and Nutritional Support
LODOVICO BALDUCCI, M.D. and MARTIN H. STEINBERG, M.D.
- 184** Radiologic Seminar CCVI: Pancreatic Arteriovenous Malformation
NANCY C. LAWHON, M.D.

SPECIAL ARTICLES

- 186** Avoiding Malpractice
W. W. EPPES, JR., J.D.
- 190** The American Legal System — Friend Not foe
BURKE C. MURPHY, J.D.
- 192** Understanding Malpractice
C. G. SUTHERLAND, M.D.
- 193** Preparation for Testimony in a Malpractice Case
C. R. MONTGOMERY, J.D.
- 194** Mississippi Medical Fraternal and Educational Society
CHARLES M. "CHUCK" DUNN

EDITORIALS

- 199** Nation Must Set Priorities
W. MONCURE DABNEY, M.D.
- 199** It Can Happen Here — And It Did!
ARTHUR A. DERRICK, M.D.

THIS MONTH

- 198** The President Speaking — Voice of Organized Medicine
- 202** Board of Trustees Conducts Summer Meeting
- 203** Council Announces Schedule for 113th Annual Session

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F-E-P CREME®

(Iodochlorhydroxyquin — Pramoxine HCl — Hydrocortisone)

The 4 in 1 Corticosteroid Cream

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- Designed for prophylactic use with diuretics and adrenocorticoids.
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- Avoids the problems of a chloride salt.

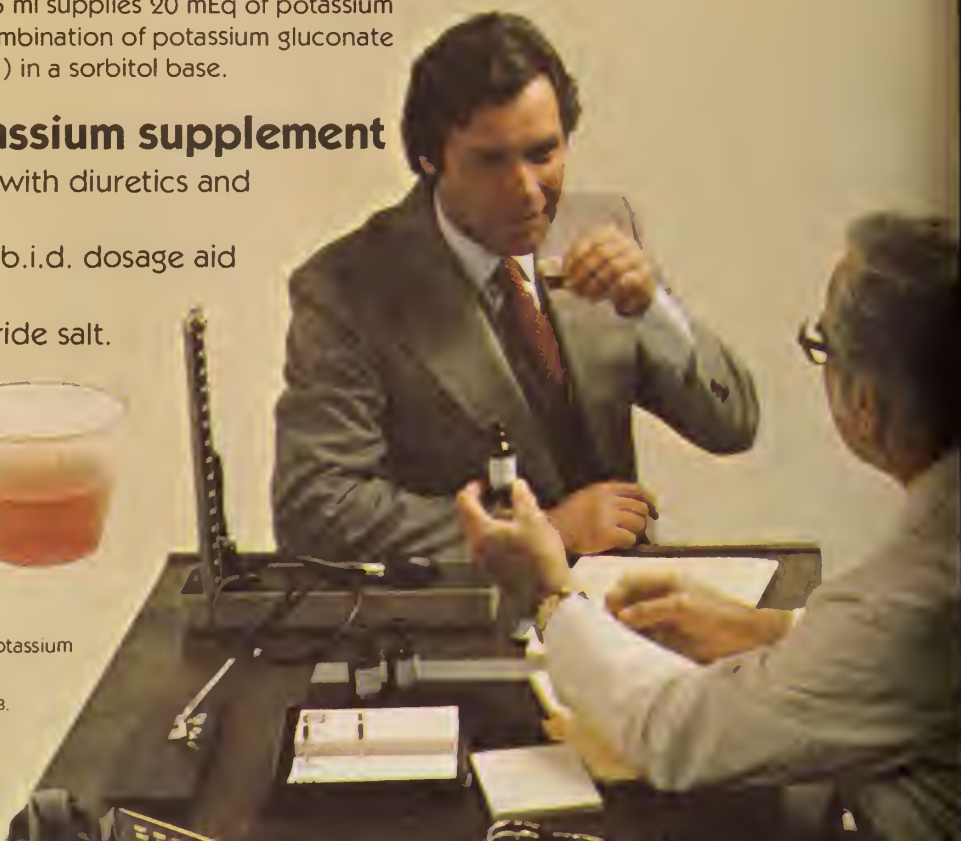
"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."¹



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

¹ Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.



For the Geriatric Patient

SU-TON[®]

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylentetrazol.	30 mg
Niacin.	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate).	1 mg
Magnesium (as Magnesium Sulfate).	2 mg
Zinc (as Zinc Sulfate).	1 mg
Iron (as Ferric Pyrophosphate, Soluble).	22 mg
Alcohol.	18%

See prescribing information on last page of this advertisement.

Please send me patient starter samples of:

☐ F-E-P CREME[®]

☐ TWIN-K[®]

☐ SU-TON[®]

Name _____

Street Address _____

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F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin.	3.0%
Pramoxine Hydrochloride.	0.5%
Hydrocortisone.	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; numular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urtica; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.

2. F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin. Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme ½ ounce (15 gm) tubes NDC 0524-0026-S1	F-E-P Creme Plain ½ ounce (15 gm) tubes NDC 0524-0025-S1
--	--

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 mEq/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice,

two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) or TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol.	30 mg
Niacin.	50 mg
Vitamin B-1.	10 mg
Vitamin B-2.	5 mg
Vitamin B-6.	1 mg
Vitamin B-12.	3 mcg
Choline.	100 mg
Inositol.	50 mg
Manganese (as Manganese Sulfate).	1 mg
Magnesium (as Magnesium Sulfate).	2 mg
Zinc (as Zinc Sulfate).	1 mg
Iron (as Ferric Pyrophosphate, Soluble).	22 mg
Alcohol.	18%

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED: Bottles of 473 ml (16 fl oz) NDC 0524-0015-16

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001

5-80

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As a privately owned 56-bed short term care facility for treating patients with psychiatric illness, emotional problems, or substance abuse, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

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Physicians who have patients that would benefit from this type of treatment approach may obtain referral information by contacting the Admitting Office.

Riverside Hospital

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NEWSLETTER

September 1980

Dear Doctor:

"Medical malpractice insurance companies, whether commercial insurers or physicians' mutuals, have a common purpose," said Tom H. Swain, EVP of the St. Paul Company, in an address before the Physicians Insurers Association. He outlined for the physician mutual group several areas in which the two insurance mechanisms could work together ...loss prevention, informed consent and tort reform. He proposed sharing ideas for loss prevention programs and proposals for improving informed consent.

Regarding tort reform, he acknowledged that recent judicial decisions have reversed some gains and stated, "the only way we're going to sort through the morass of our civil justice system is to let someone else do it. Too many of us are too involved, too many trial lawyers are too involved, to look objectively at the system."

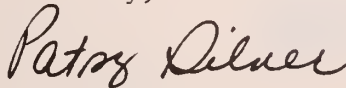
"Our position on the tort system at the St. Paul has been to make the general public aware of how the system operates and what it costs. Despite our belief of overuse and excesses, we think the public has to make the ultimate decision about whether it wants reform, or wants to continue paying the soaring costs of maintaining the present system," Swain reported.

He pointed out that the St. Paul provides support to the Rand Corporation's Institute for Civil Justice, which is attempting to "objectively study our justice system and its impact on society." He noted the Institute is financed by a cross-section of American commerce and industry, with significant financing coming from all kinds of corporations, and suggested the physician mutuals consider providing funds, also.

Stating that observers of the medical malpractice scene forecast new impending problems for malpractice insurers, he said, "Medical liability insurance is like a roller coaster, and right now we could be on the verge of one of the downhill runs." He declared that cooperation between the two groups will be essential in keeping a focus on the major goal of reducing the frequency and severity of medical claims.

He noted that when experience deteriorates and rate increases result, critics become more vocal; and he observed that the critics are, for the most part, plaintiffs' attorneys rather than the premium-payers. More discussion of the subject of medical malpractice appears elsewhere in this issue of Journal MSMA, in several articles by physicians, attorneys, and an MMFES executive.

Sincerely,





Patsy Silver
Managing Editor

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UMC Announces Faculty Promotions

Seven associate professors who moved up to the rank of professor were among 22 School of Medicine and centerwide faculty members who received promotions at the University of Mississippi Medical Center this summer.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the promotions following approval by the Board of Trustees, State Institutions of Higher Learning.

School of Medicine faculty promoted to the rank of professor are Dr. William G. Johnson, psychiatry and human behavior; Dr. James L. Hughes, surgery (orthopedics); Dr. Thomas J. Herrin, anesthesiology; Dr. Gwendolyn Hogan, neurology; and Dr. John F. Jackson, medicine. Centerwide faculty members moving up to the rank of professor are Dr. David B. Young, physiology and biophysics, and Dr. Harihara Mehendale, pharmacology and toxicology.

School of Medicine faculty who were promoted to the rank of associate professor are Dr. John V. Richey, anesthesiology; Dr. Bobby J. Heath, surgery; Dr. Edward F. Meydrech, preventive medicine; Dr. Geary Alford, psychiatry and human behavior; Dr. Theodore D. Lampton, medicine; Dr. Shri Kant Mishra, neurology; and Dr. James A. Joransen, pediatrics. New associate professors on the centerwide faculty are Dr. Roger A. Norman and Dr. R. Davis Manning, both in the department of physiology and biophysics.

Moving up to the rank of assistant professor in the School of Medicine are Dr. Ernesto D. Ruvinsky, Dr. Feryal Rahman and Dr. G. Rodney Meeks, obstetrics and gynecology; Dr. Nell Ryan, neurology; and Dr. Douglas L. Tai and Dr. Nancy C. Lawhon, radiology.

Forrest General Hospital Plans Gastroenterology Seminar

A postgraduate course, "Advances in Gastroenterology," will be sponsored by the Forrest General Hospital in Hattiesburg on Nov. 6.

The program will feature a discussion of gastroenterology topics of interest to primary care physicians. Speakers are Dr. Jack Welsh of the University of Oklahoma Medical Center and Dr. James L. Achord of UMC's Division of Digestive Diseases.

For more information, contact the Department of Continuing Medical Education, Hattiesburg Clinic, P.A., 415 S. 28th Ave., Hattiesburg, MS 39401.

Health and Safety Tip

From the American Medical Association

535 North Dearborn Street/Chicago, Illinois 60610

Air Travelers Face Jet Lag Fatigue

Jet Lag Is Hazard

The most obvious contributor to stress in the modern world travel style is "jet lag fatigue."

An air traveler who departs from New York for Italy at 5:30 p.m. crosses seven time zones during a seven-hour flight, and arrives in Rome at 7:30 a.m. Rome time. But it is 12:30 a.m. in New York, the middle of the night for the traveler.

There is great variability in the effects of time zone changes and in one's speed of adjustment, the American Medical Association points out. The young adjust easily; older individuals more slowly.

Tourists planning months in advance for an overseas vacation should take conditioning exercises; a two to three-week program of walking up to three miles a day. Avoid the Bon Voyage party, unless it is given two or three days prior to departure.

In flight, remember that two drinks at cruising altitude are the equivalent of three or four on the ground. Eat moderately and drink sparingly. Get up and walk about the plane frequently.



The single most important requirement on arrival at the overseas destination is sleep and rest. A flight to Europe should be followed by a good night's sleep before sight-seeing or business.

A simple formula often is used by tour groups. It calls for rest stops of a day after crossing four to six time zones, and two days after seven to ten zones. As crossings approach a complete reversal of the day-night cycle, three days of rest are welcomed by any traveler, particularly if in late middle age or afflicted with insomnia.

North-south flights cross no time zones, or only one, and should result in only normal fatigue.

A pretravel health review with your physician may help forestall health emergencies while on tour. There are some individuals who should not board long jet flights. These include women beyond the eighth month of pregnancy, infants less than two weeks old, individuals with contagious disease, those with large unsupported hernias, psychotics, acute respiratory infection patients (severe colds or flu), those with certain heart problems (ask your doctor), and poorly stabilized convalescent postoperative or handicapped people.

Jet lag fatigue may be held to a minimum by proper planning and proper rest on arrival.

August, 1980
Frank Chappell
Science News Editor
AMA

A woman with dark hair tied back, wearing a white lab coat, is leaning over a large black tray. She is holding a pair of brown leather gloves. The tray is filled with many small, orange, elongated objects, possibly seeds or small fish, arranged in rows. The background is dark and industrial, with a metal structure visible. The text "getting back to business" is overlaid in white, bold, sans-serif font on the right side of the image.

**getting back
to business**

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

**for moderate anxiety
with depression**

dual-action[®]
Triavil

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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*Please see the following page
for a brief summary
of prescribing information.*

by providing symptomatic relief
of moderate anxiety with depression

Dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:

TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone. **Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmic involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonian agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema, reversed epinephrine effect, hyperglycemia, endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement, hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. **Cardiovascular:** Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. **CNS and Neuromuscular:** Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. **Anticholinergic:** Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. **Allergic:** Skin rash; urticaria; photosensitization; edema of face and tongue. **Hematologic:** Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. **Gastrointestinal:** Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). **Endocrine:** Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. **Other:** Dizziness, weakness, fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. **Withdrawal Symptoms:** Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1-3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

JSTR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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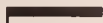
And with good reason. The Newtron® electrostatic air cleaner is a revolutionary new device that allows allergy patients to breathe clean air in their homes and offices — at a much lower cost than has ever been possible before.

In fact, the Newtron® is the only reasonable answer to the problems caused by pollen, dust, smoke, and other air pollutants. It requires no electricity, never needs to be replaced, requires no maintenance other than a monthly rinsing with tap water, and comes in standard filter sizes to simply replace the existing throw-away filter in heating and air conditioning systems. Even more importantly, it far out-performs all other cleaners, including electrically powered models costing more than three times as much.

Per Cent (%) Efficiency

0 10 20 30 40 50 60 70 80 90 100

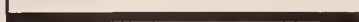
Throw Away Fiber Glass Filter



Powered Air Cleaners



Newtron Electrostatic Air Cleaner



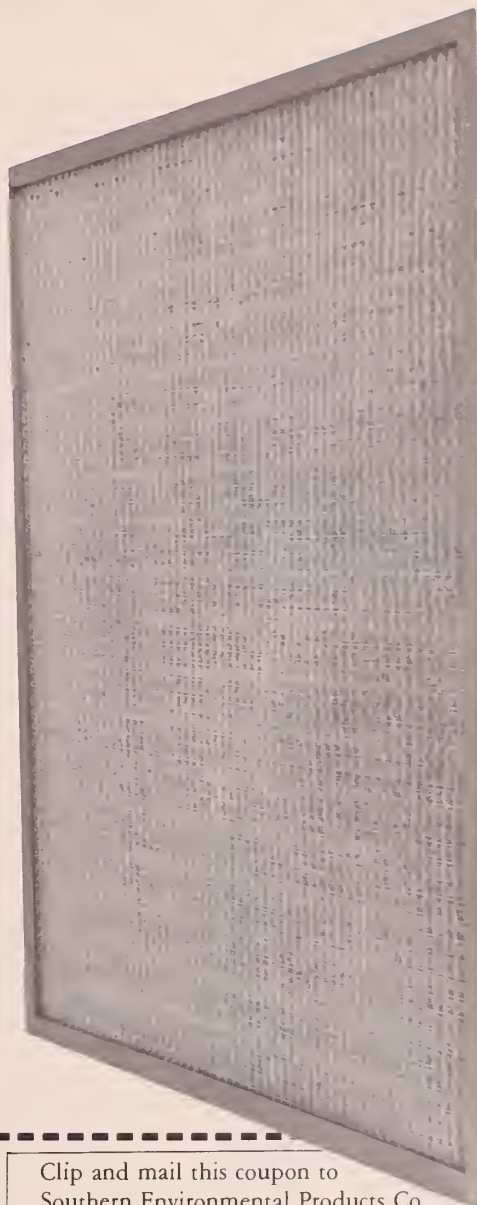
In the past, high costs and complicated installation have put truly clean air out of the reach of most allergy patients. Now that the Newtron® is available — and has been proven effective in hospitals, businesses, private homes, and apartments — your patients will be asking for your approval or opinion.

Please allow us to send you a complete information package on the Newtron®. No salesman will call, either in person or by telephone (unless you request it). The price of the Newtron® varies from \$180 to \$190, according to size. (Master Charge® and VISA® are accepted.) Professional discounts on Newtron® electrostatic air cleaners are available to physicians who wish to purchase one unit for their personal use.

Newtron®

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Newtron® is a registered trademark of Newtron Products Co., Cincinnati, Ohio
The generic name is electrostatic air cleaner



Newtron

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Please send complete information on the Newtron®
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Manage your patient time for quality care. Manage your practice for greater efficiency.

A medical practice is communications intensive. Bell — at the forefront of communications knowledge — offers systems and services to help you make more and better use of your doctor-patient time. And increase staff productivity by increasing efficiency in office procedures.

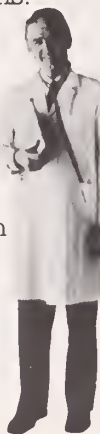


Eliminating manual information handling reduces clerical work so your staff can focus on patient care.

Streamline communications.

Numerous practice management problems are fundamentally related to communications.

It takes an average of 75 information exchanges, verbal and on paper, involving doctors, patients, office personnel, hospitals, outside providers, to move each patient from appointment scheduling through payment processing. Bell communications systems can help you manage these exchanges more effectively.



Improve patient flow. And cash flow.

Cut down or cover no shows. Speed collections. Reclaim bad debt write-offs. A Bell Phone-Power Program can teach your staff proven techniques for handling these problems better.

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Decrease waiting time. Eliminate conflicting appointments. Level out peaks and valleys in patient load. Bell data terminals that access automated scheduling systems can help avoid clerical errors and needless disruption of the doctor's schedule.

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Eliminate time-consuming footwork. Bell communications systems can provide instant inter-office consultation, personnel tracking, patient location.

Expedite billing and claims processing.

Recapture lost-to-error billings. Reduce turn-around time on third party reimbursements. Relieve the paperwork burden. Bell data terminals such as the Dataspeed® 40 will access a computer or service bureau to provide quick and accurate recording and retrieval of billing and claims information.

Earn CME credit.

Bell offers medical-oriented seminars to show you how the latest communications technology and techniques can improve your practice management procedures. In one short, enlightening forum, you'll gain valuable information to help you improve practice profitability. And you'll earn Category 2 CME credit.

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DATELINE

HMO Management Training Underway

Potomac, MD - Candidates are being recruited for the first HHS-sponsored training program for HMO managers, scheduled to begin in January. Authorized by 1978

amendments to the federal HMO Act, the course is the first on a nationwide basis to provide specific HMO training to health care managers. Some 45 HMOs will serve as preceptors for five-month-long internships which follow a month of classroom instruction. HHS predicts a doubling of HMOs by 1990.

Hypertension Study Focuses on State

University, MS - Attala, Carroll, Grenada, Holmes and Montgomery counties will be involved in a five-year project to test a new concept in hypertension control. Funded by \$2.5 million from the National Heart, Lung and Blood Institute, the project will feature a massive education program encouraging checkups and proper use of medication, and will include research into social and environmental factors which may contribute. The area has one of the nation's highest hypertension rates.

Report Suspected Formaldehyde Exposure

Jackson, MS - Physicians who have patients with eye irritation or unexplained chronic upper respiratory infections should be alert to the possibility of formaldehyde exposure in the home, says the Bureau of Disease Control. Increasing numbers of complaints have been traced to formaldehyde vapors in building materials, foam insulation or carpeting, primarily in mobile homes. To document the extent of the problem in Mississippi, physicians are urged to report suspected exposures.

Medical Education TV Series Begins

Jackson, MS - Patients may find "The Body in Question" interesting. The 13-week series begins Sept. 30 at 9:00 p.m. on Miss. ETV. Dr. Jonathan Miller, writer and

host, traces advances in medical knowledge from the Renaissance to the present, showing how these developments are related to events in politics and trends in culture. He recreates early experiments, performs a post-mortem, and uses art, history, literature and special effects to clarify complex medical knowledge.

Management Seminars Are Scheduled

Jackson, MS - Office management workshops for medical office personnel will be conducted later this month in Tupelo, Biloxi and Jackson. Sponsored by MSMA and AMA,

the seminars will provide information on medical collections, scheduling the doctor's time, and office supervision. Registration, on a first come, first serve basis, is limited. For more information, check the insert with the August 20 "Blue Sheet" or call the MSMA office.

Genetics Group Meets at UMC



Among speakers for the Southern Genetics Group summer meeting at the University of Mississippi Medical Center were, from left, Dr. Wayne H. Finley of Birmingham and Dr. T. F. Thurman of New Orleans. Dr. John F. Jackson, right, UMC professor of preventive medicine (medical genetics) presided. Dr. Thurman's topic was "Inbreeding in a Louisiana Isolate." Dr. Finley spoke on genetic services delivery organization. Sponsors were the Southern Genetics Group, the UMC Department of Preventive Medicine and the Medical Center Division of Continuing Health Professional Education.

UMC Adds to Faculty

Two assistant professors and an instructor have joined School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

Dr. Benjamin Sanford was named an instructor in medicine. Dr. Thomas Buttke joined the centerwide faculty as an assistant professor of microbiology and Dr. Yoshifumi Tanaka was named visiting assistant professor of physiology and biophysics.

Dr. Norman C. Nelson, UMC vice chancellor, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. Sanford holds a B.S. degree from Mississippi State University and earned the M.D. at University Medical Center in 1977. He has been in residency training at UMC since 1977.

Dr. Buttke, a B.A. graduate of Southampton College of Long Island, earned the M.S. and Ph.D. degrees at the University of Florida. He held University of Florida Graduate Council Fellowship in 1975 and the University of Florida Center for Gerontological Studies Fellowship in 1978. He has been a postdoctoral fellow in chemistry at Harvard University since 1978.

Dr. Tanaka earned the M.S. and M.D. degrees at Kyoto Prefectural University of Medicine in Kyoto, Japan, and has been an instructor in anesthesiology there since 1973.

QuinammTM

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

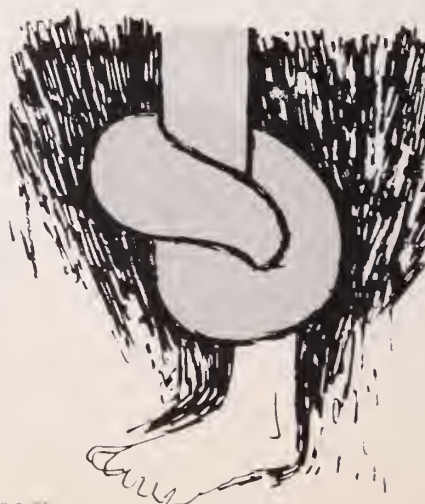
U.S. Patent 2,985,558

Merrell

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for Knotts in the night



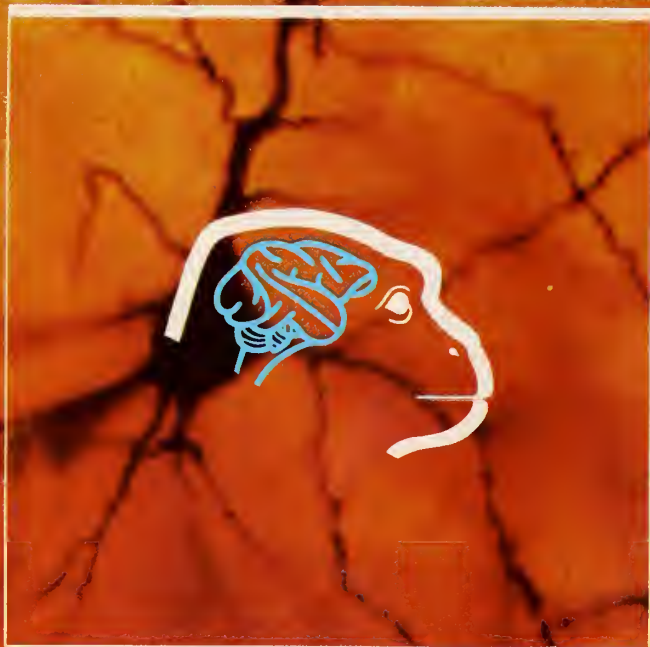
QuinammTM

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.



Golgi-stained neurons from the brain of a monkey.



Pharmacology Recapitulates Phylogeny

Recently discovered binding sites in the brains of primates and other vertebrates displaying high affinity for benzodiazepines have stimulated the search for an endogenous substance which may interact at these same binding sites and may also have anxiolytic properties.

While the search continues for a naturally produced anxiolytic, you can rely on Librium for predictable patient response in the treatment of anxiety.

Librium[®] IV
chlordiazepoxide
HCl/Roche
5mg, 10mg, 25mg capsules

The origin
of the species



Please see next page for summary of product information



Tail of whipworm
(*Trichuris trichiura*)

Vermox[®]: the only anthelmintic highly effective against whipworm.

	Cure Rate	Egg Reduction
VERMOX [®]	68%*	93%**
Mintezol ¹	35%†	45%††
Antiminth ²	Not Indicated	
Povan ³	Not Indicated	

Also highly effective against roundworm and hookworm

Since whipworm, roundworm and hookworm are all soil-borne helminths, mixed infections are not uncommon. Only one anthelmintic exhibits high efficacy rates for all three nematodes: whipworm—68%; roundworm—98%; hookworm—96%. That agent is VERMOX.[®]

Please see following page for Summary of Prescribing Information.

Broad-spectrum coverage in mixed helminthic infections

Vermox[®] TABLETS
(mebendazole)



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*

© Janssen Pharmaceutica Inc. 1980 JPI-023



**Broad-spectrum
coverage in mixed
helminthic infections**

Vermax[®] TABLETS
(mebendazole)

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions PREGNANCY: VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse Reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and Administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
2. Registered trademark of Roerig.
3. Registered trademark of Parke-Davis.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

*Committed to research...
because so much remains to be done.*



Dr. Edgar Johnson of Hattiesburg, immediate past president of the Mississippi Academy of Family Physicians, presented the Outstanding Senior Award to Dr. Paul Eugene Sheffield of Jackson, during MAFP's recent annual meeting.

POSTGRADUATE CALENDAR

FUTURE CALENDAR

Oct. 3, 1980

CONTINUING MEDICAL EDUCATION SESSION, SCHOOL OF MEDICINE ALUMNI MEETING
University Medical Center, Jackson

Oct. 7, 1980

MISSISSIPPI THORACIC SOCIETY MEETING
University Medical Center, Jackson

Oct. 10-11, 1980

ADVANCED CARDIAC LIFE SUPPORT PROVIDERS COURSE
University Medical Center, Jackson

Nov. 6-8, 1980

FAMILY PRACTICE UPDATE
Jackson Hilton, Jackson

Nov. 14-15, 1980

VASCULAR ANOMALIES OF THE BRAIN: TRADITIONAL AND MODERN CONCEPTS
Holiday Inn Downtown, Jackson

Dec. 4-5, 1980

MISSISSIPPI PERINATAL POSTGRADUATE COURSE 1980
Holiday Inn Downtown, Jackson

For information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

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The active and involved physician has to rely on comprehensive insurance programs tailored to fit the day-to-day special needs of his profession.

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WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] ^{CV}

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation. The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Meizazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoadosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa. 19101



FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in one tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see Warnings) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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ORIGINAL PAPERS

Prolonged Remission of Metastatic Rhabdomyosarcoma: The Use of Chemotherapy and Nutritional Support

LODOVICO BALDUCCI, M.D., and
MARTIN H. STEINBERG, M.D.
Jackson, Mississippi

EMBRYONAL RHABDOMYOSARCOMA is a relatively rare neoplasm affecting children and young adults. It is generally metastatic at the time of diagnosis. Surgery and radiotherapy do not prolong patient survival. Chemotherapeutic combinations employing Adriamycin may produce complete remission and prolong survival in this disease, when the patient can tolerate the toxicity of this treatment.

We report the case of a young man with widely disseminated embryonal rhabdomyosarcoma, who achieved a long lasting complete remission following treatment with chemotherapy and total parenteral nutrition. We wish to emphasize the synergistic effects of these two treatments in allowing complete remission to be obtained.

Case Report

A 26-year-old man was admitted to the Jackson VA Medical Center on Oct. 29, 1978, complaining of nausea and vomiting of 20 days duration.

Two years earlier, a rhabdomyosarcoma of the left ascending ramus of the mandible was treated with radiation therapy (6000 rads) at another institution. He received adjuvant chemotherapy with Actinomycin D, Cyclophosphamide and Vincristine for one year.

From the Veterans Administration Medical Center, Jackson, MS.

On admission, radiographs of the small bowel showed several areas of obstruction in the proximal jejunum, presumably due to metastatic disease. A gastro-jejunostomy was performed and diffuse metastatic deposits were observed on the wall of the intestine. Biopsy revealed embryonal rhabdomyosarcoma.

The authors report the case of a young man with widely disseminated embryonal rhabdomyosarcoma, who achieved a long lasting complete remission following treatment with chemotherapy and total parenteral nutrition. The authors emphasize the synergistic effects of these two treatments in allowing complete remission to be obtained.

Twenty days after operation, the patient developed symptoms of small bowel obstruction. An upper gastrointestinal series (see Fig. 1) showed obstruction of the distal portion of the small bowel secondary to metastatic disease. The patient was started on Cyclophosphamide, Adriamycin and Triazenoimidazole Carboxamide in four week courses.

After two courses of chemotherapy there was no improvement. Since admission he had lost about 40

RHABDOMYOSARCOMA / Balducci

lbs and the serum albumin was now 2.8 gm/dl. It was decided to administer chemotherapy every three weeks, but the patient's ability to withstand the toxicity of this treatment, because of his poor nutritional status, was questioned. Another concern was death from starvation. Peripheral hyperalimentation was started on Jan. 26, 1979. Two thousand milliliters of Intralipid and a solution containing 500 ml of D₁₀W, 500 ml of Travasol 8.5% and 20mEq of Ca gluconate were given through a brachial vein, for a 12-hour period each day. The two solutions were mixed in a Y connector before reaching the vein. During the following 12 hours, 1,000 ml of normal saline with the addition of 40 mEq of potassium phosphate, 20 mEq of magnesium sulfate and one ampoule of multivitamins were administered.

On March 2, 1979, after six weeks of nutritional support and two cycles of chemotherapy at three week intervals, the patient was discharged without

obstructive symptoms. A radiograph of the upper gastrointestinal tract on May 1979 was within normal limits (see Figure 2). On June 1979 no disease was found at a "second look" laparotomy. Since that time the patient has been off chemotherapy and clinically free of disease.

Comment

Adriamycin containing combination chemotherapy may produce a response rate of 30%-60% in patients with soft tissue sarcoma.^{1, 2} Our case emphasizes the fact that the time interval between two successive courses of Adriamycin is very important for achieving complete remission.¹ A three week interval between treatments is optimal, if this can be tolerated.

The severity of our patient's malnutrition at the time hyperalimentation was started, is reflected by his weight loss and serum albumin level. A serum albumin level of less than 3 gm/dl is a poor prognostic sign and it indicates that the patient is prone to



Figure 1. UGI series obtained 20 days after gastrojejunostomy. Almost complete obstruction of the proximal jejunum is observed.



Figure 2. UGI obtained after treatment with chemotherapy and hyperalimentation. No abnormalities are observed.

severe infection and possibly death from starvation.³ Severe malnutrition is known to cause poor tolerance of chemotherapy toxicity⁴ and decreased response to chemotherapy.⁵

It seems reasonable to withhold nutritional support from patients with obviously terminal disease when cure or prolonged palliation is impossible. For this patient, the availability of effective chemotherapy justified the use of parenteral nutrition.

In the past, total parenteral nutrition was administered exclusively through the superior vena cava. This was necessary because of the rapid sclerosis of peripheral veins when challenged by the hyperosmolality of these high carbohydrate solutions. The complications of parenteral nutrition through a central vein⁶ make its use impractical when a properly trained team is not available.

Since soy bean extract (Intralipid) has been available as a calorie source, total parenteral nutrition using peripheral veins has been possible.⁷ When Intralipid mixes with the protein containing solution (Travasol) in the Y tube, prior to entering the vein, an osmolality (500 mOsm) well tolerated by the vein wall is achieved. Our patient received uninterrupted treatment for six weeks without developing a reaction at the site of injection. The only limitation of Intralipid treatment is that no more than 2500 calories can be administered daily. Very seldom, however, do patients need a higher calorie intake. The only described side effect of Intralipid⁷ is transient hypertriglyceridemia and it is unlikely that this has any clinical significance.

This case illustrates: (1) that patients with metastatic embryonal rhabdomyosarcoma may achieve a prolonged control of their disease with aggressive combination chemotherapy containing Adriamycin; (2) that nutritional support may play an essential and synergistic role in the achievement of these results; and (3) nutritional support can be safely administered through peripheral veins, when Intralipid is used as a source of calories. ★★★

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Radiologic Seminar CCVI: Pancreatic Arteriovenous Malformation

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Jackson, Mississippi

PANCREATIC ARTERIOVENOUS MALFORMATION is known to be associated with Osler-Weber-Rendu disease, although it may be an isolated finding. In either case, it is rare. The angiographic findings are specific and help not only in diagnosis but also in surgical management. Gastrointestinal hemorrhage is a frequent complication.

Case Report

This 50-year-old black female with known hereditary hemorrhagic telangiectasia (Osler-Weber-Rendu disease) had had repeated admissions for massive epistaxis and persistent anemia. On this admission she was noted to have hematest positive stools, and an angiogram was requested.

The initial flush aortogram shows the entirety of the pancreas blushing with arteriovenous malformation (see Figure 1). Arteriovenous malformations are also present in the ileum and there is early venous drainage with opacification of the superior mesenteric and portal views (see Figure 2).

In this case, surgical resection was rejected because of multiplicity of lesions and other medical problems.

The visceral angiodysplasia of hereditary hemorrhagic telangiectasia is pleomorphic. Pancreatic arteriovenous malformation is a rare but well recognized member of the spectrum. It has been proposed that loss of regulatory sphincteric mechanism of the arteriolar-capillary junction in hereditary hemorrhagic telangiectasia results in unrestricted overflow of the arterial blood into capillaries and venules, producing an A-V shunt. Eventually, marked dilatation, elongation, and tortuosity of arterioles, capillaries, and venules occur.¹

The angiographic findings consist of dilated and tortuous feeding arteries, racemose intrapancreatic

vascular network, and early filling veins. Although the pancreatic stain is intense, it is early and rapidly regresses. The differential diagnosis includes pancreatitis and certain hypervascular neoplasms. In acute pancreatitis the stain may be intense but is during the parenchymal phase and no early veins are seen. Hypervascular neoplasms include cystadenoma, islet cell adenomas, rare carcinomas, and metastases. They usually stain densely in the venous phase but no dilated feeding vessels or early draining veins are present. The rapid uptake of contrast, blush, and early drainage of the arteriovenous malformation is a unique feature distinguishing it from other pancreatic lesions.^{1, 2, 3, 4}



Figure 1. Aortic Flush – AVMs outline the pancreas.

Sponsored by The Mississippi Radiological Society.
From the Department of Radiology, University Medical Center,
Jackson, MS.



Figure 2. SMA injection – AVMs in head of pancreas and ileum; early venous drainage by SMV and portal veins.

Massive hemorrhage is an unusual complication of pancreatic disease in general but is a frequent complication of pancreatic arteriovenous malformation.⁵ Gastrointestinal bleeding may occur by one of three methods: (1) into the pancreatic duct and subsequently into the duodenum; (2) be associated with intestinal arteriovenous connections with direct hemorrhage; (3) produce portal hypertension with esophageal varices.⁶ In acute gastrointestinal bleeding, interpretation of the angiogram can be difficult since it is often impossible to decide which of the multiple lesions is bleeding if there is no frank extravasation of contrast.

Arteriovenous malformations of organs have been managed by total extirpation of the organ or at least the involved portion. Simple interruption of feeding arteries usually will poorly palliate the problem and collateral arterial inflow rapidly augments through a low resistance arteriovenous connection. The rich collateral arterial supply to the pancreas makes it readily apparent that nothing short of radical ablative surgery can control this vascular angiodysplasia and associated bleeding. Angiographic mapping is valuable for successful surgical resection. For example, in the case presented, the procedure dictated would have been a total pancreatectomy and partial small bowel resection. Generally, one is reluctant to subject patients with noncancerous conditions to such an extensive surgical procedure, but this may be the only means of definitive management of a disabling and potentially lethal malformation.⁷ ★★★

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Avoiding Malpractice

W. W. EPPES, JR., J.D.

Meridian, Mississippi

DURING THE PAST FEW YEARS I have been associated with the defense of a number of so-called malpractice cases in Mississippi. When I first began to concentrate my efforts into this field, I held the incorrect assumption that medical malpractice was only a subcategory of general negligence law. It did not take me long to realize that there are a number of significant differences and special rules that are applicable only in malpractice cases. When I use the term "malpractice" I am alluding not only to medical malpractice, as we are seeing an ever increasing number of actions challenging the professional competency and activities of dentists, architects, and lawyers.

Malpractice Claims Increasing

Why are we having so many medical malpractice claims when ten years ago they were infrequent? While a number of national studies have placed the suspected reasons in various orders, it is clear that on the local level: (1) the physician no longer is held in the sacred position of respect he once enjoyed; (2) the "wall of silence" has totally collapsed, as currently there are many physicians willing to testify against another physician; and (3) many lawyers have been forced into the malpractice field as a result of the absence of available work in other legal fields.

On the Mississippi level, the greatest causes for the increase have been the adoption of the "no fault" approach to motor vehicle accidents, the uninsured motorist law, and other types of legislation which have deprived many lawyers of cases in those fields.

Status of Mississippi Law

In the entire history of Mississippi Jurisprudence, less than 40 cases involving medical malpractice have been decided by the Mississippi Supreme Court; therefore we have very few judicial guidelines in Mississippi. Furthermore, many important legal principles that have been settled elsewhere, remain open legal questions in Mississippi. For example, the much discussed "Captain of The Ship Doctrine"

has never been positively decided, one way or the other, in Mississippi. Another vitally important but unanswered question is whether or not a family practitioner is competent to express an opinion opposing the opinion of a specialist. I believe this will be permitted simply because the family practitioner has more knowledge on the subject than a layman, and thus he qualifies as an expert under our evidence rules. The "locality rule" is on the way out. At least one Mississippi Supreme Court decision and one Mississippi Federal Court decision have substantially eroded this doctrine.

Since many important legal questions are totally open and the Mississippi Supreme Court is free to go either right or left with them, many times we are required, in the handling of Mississippi malpractice cases, to make enlightened predictions as to what the law will be prior to the time our court rules on it. When a physician comes into my office with a copy of *The Times Picayune* citing a Louisiana case or the latest issue of *Medical Economics* citing some foreign jurisdiction that supports his idea of "the law," I must attempt to convince him that, at best, these foreign cases are only persuasive, and certainly they are not binding on our court.

In 1970 in *Ross v. Hodges*, 234 So.2d 905, the Mississippi Supreme Court rendered a unanimous opinion which received wide circulation in malpractice literature. There our court stated:

"It must be borne in mind that a surgeon's primary concern . . . is and should be the best possible treatment of his patient's illness, not preparation for the defense of a possible law suit."

Now this sounds great and as if our court realized just how difficult it is to practice good medicine in this day and time. Still I must remind you that times have changed and our court has changed, and I have serious doubts that the present court will pay much attention to this general comment.

I would like to mention the common problem of publicity attendant to medical malpractice cases. The press seems to have adopted a policy of printing in large headlines and at great length all or a part of the contents of every malpractice case filed. This makes for a terrible situation since the initial article gives only one side of the story, the plaintiff's side.

Mr. Eppes is a practicing attorney in Meridian, MS.
Condensed from an address presented at the Annual Membership Meeting of the Mississippi Medical Fraternal and Educational Society, April 27, 1980, in Biloxi, MS.

My first suggestion, then, may be worthwhile: If you have any influence with your local newspaper editor, mention this problem to him and remind him of the terrible ordeal a physician encounters for the first few days he is "in print." Do not attempt to get the editor to suppress the story. Do attempt to persuade him to have his writers insert at the end of the story a strong paragraph that the news article contains only the *allegations* that have been made in the suit, that the article presents only one side of the story, and that the physician has 30 days in which to respond to these charges. Such a paragraph does take some of the "sting" out of the article and may help counter the strong first impression the readers (who will later be the jurors) obtain as a result of reading about the filing of a malpractice suit.

Countersuits

In many of the cases I handle, initially the defendant physician often says something like this: "I am going to countersue Attorney Jones for filing this junk and if you won't do it, I will get my own personal attorney to do it." Now, my job as trial counsel is to tell you what the law is, not what it ought to be and not what is fair or moral. I leave fairness to legislators and morals to preachers. My job is to know the law. So, let me tell you right now, that what that doctor client wants done *can't be done*. There are procedural prohibitions; plus, it is mandatory that the defendant physician win the malpractice case before any such action comes into being. It also must be shown that the attorney had actual malice in the filing of the suit. His not having made any investigation into the fact is insufficient. Finally, there is not a single reported decision in American legal literature which has gone to the court of last resort where an attorney has been held liable for filing such a case. I don't care what you have read in *Medical Economics*, that is a fact!

What the Physician Can Do

Another problem that we encounter is that of personalities. Often sympathies or jealousies may influence the decision of a jury. We attempt to combat this problem from the very beginning of every trial by seeking a solemn pledge that the jury will follow the law and leave sympathy at the courthouse steps and not take it with them into the jury box. Sometimes this works; sometimes it does not. But there is no doubt that a very strong correlation exists between the existing reputation of the physician in the community and the outcome of his malpractice trial. We need your assistance to combat the sympathy approach with reasonable, articulate, demonstrative

medical testimony by local physicians. We need the assistance of practical physicians who can communicate with us and even more important, who can identify with and persuade the local jurors. My second recommendation to you is that you make yourself readily available to counsel who are attempting to defend any physician in your area.

Many of the malpractice defense attorneys have no medical training whatever. When we are drawn into one of the highly technical cases we must first educate ourselves as to the medical aspects of the case. This can only be done by extensive reading of medical books and long conferences with physicians who can explain the technical aspects of the case to us.

I urge you to help us defend you. All the legal brilliance, oratory and research in the world does not even begin to override personal and lifelong friendships many of you will have with local jurors.

When to Report a Claim

I was asked to make some general observations about when and at what stage in a threatened malpractice claim you should report it. That is a difficult thing to describe in general terms, for we are constantly dealing with entirely different factual situations. Your policy provides that you must report upon "... obtaining knowledge or becoming aware of any alleged injury . . . which may subsequently give rise to a claim . . ." and also that you give notice "... as soon as practical. . . ."

Certainly you should report at once if you receive a telephone call or mail from an attorney advising you that he represents a patient who is complaining of your treatment. While counsel is very likely to speak to you in terms of "we are good friends and I don't want to see you embarrassed . . ." it is critical that you report this at once. Likewise, if your patient expresses substantial dissatisfaction with your efforts or slyly threatens to employ counsel or suggests that you "drop your bill," you should report. I think the best rule for you to adopt is that if you are in doubt, report it, and get some advice as to how to deal with the given factual situation.

Incidentally, be very careful of your comments to your patient and his counsel when discussing a claim by telephone. The patient must be invited to your office for a personal conference if any type of conference is to be held.

We are experiencing entirely too many problems resulting directly from physicians attempting to handle their own case in the early stages. Too many times the physician makes condescending statements

or writes letters which, when taken out of context, can become disastrous. Your insurance carrier, its claim people and attorneys can give you invaluable advice in the early stages as to what to do, and more important what not to do. Never commit yourself to a course of action or a statement without first obtaining their advice.

It is my personal observation that the physician against whom a claim is made talks too much. I realize that it is just natural to share your woes and problems with your professional associates and that it is natural to defend your actions before your peers. Still, all too often we hear of the physician-defendant undertaking to argue his own case in the hospital halls and the doctors' dining room. This brings on just what you don't need . . . more talk about your case. Your colleagues' subsequent remarks just might afford the patient or his counsel significant encouragement to proceed with the case.

Remember you are in a game where you do not know all of the rules, and the rules change frequently. You can compound your problems very easily by serving as your own counsel. My best advice to you is say and do as little as possible; certainly put nothing in writing and refer the matter to your insurance carrier. We will then look at the matter objectively following a full investigation, and hopefully we will not be making any bad judgments in your behalf.

Importance of Records

Another suggestion I have for you is one you will detest. It concerns keeping hospital charts current. I know your problem, and I sympathize with you for the demands made upon you by your patients, the insurance companies, your civic responsibilities and your home life; but let me tell you about incomplete charts. Any enlightened hospital administrator will, upon presentation of a properly signed medical authorization, furnish the patient or his attorney with a copy of his chart. If the chart is incomplete at that time, the effect can be disastrous. Not only does this demonstrate inefficiency and inattention on the physician's part, but frequently we find the physician later going back and completing the chart, not knowing the patient has already obtained an incomplete copy. Later, plaintiff's counsel formally demands production of the original chart. We then produce it and it contains material that was not on the chart at the time they obtained a copy earlier. Immediately we are met with a claim of fraud and "record doctoring." Not only is this very embar-

rassing, but it lends credence to a claim that "something is being hidden" and the records have been altered after the fact.

Continuously be aware of the fact that the patient's chart and your treatment are of a highly confidential nature. It is clear that the wrongful disclosure of this confidential information without proper authorization constitutes an actionable tort. Make certain that you have a proper medical authorization in your possession before releasing the information requested. If you don't have a good authorization in printed form for your regular use, I urge you to get one. Beware of the two line authorizations frequently received in the mail from the patient or his counsel, as they are too limited in scope. Your office routine would be much improved if you had a package of authorizations and insisted upon the use of your own forms in every instance.

Abandonment and Referral

Allegations of abandonment are now number seven on the frequency charts. These are among the most difficult allegations to handle because it is documented when you did and did not see your patient. There are many instances where it is not medically imperative that you see your hospitalized patient every day, but this is difficult to explain to a layman juror.

Recently our court has spoken rather positively (and for the first time) in the area of referrals. There is a paucity of law on the national level detailing at what point a family practitioner must refer a patient; but it now seems clear that, in Mississippi at least, if the family practitioner ever concedes that the case can better be treated by a specialist, assuming that one is readily available, referral is required. The referral must be positive and unqualified; that is, the recommendation to see the specialist must be made very clear and it must have no strings attached or indirect promises. A failure to refer under the stated circumstances will subject the practitioner to the standard of care of the specialist in the medical field. In view of this case, the enlightened family practitioner should take a good long look at referral whenever he has reason to believe (and certainly if he admits to the patient) that the results of the specialist are likely to be substantially greater than his own.

Informed Consent

An allegation of the lack of informed consent consistently is the fifth most common allegation in malpractice suits (see Table 1). You can find many definitions both in medicine and law, but I think the

TABLE 1
TWELVE MOST COMMON ALLEGATIONS
IN MALPRACTICE SUITS

-
1. Improper treatment
 2. Failure to diagnose
 3. Anesthesia-related
 4. Surgery
 5. Informed consent
 6. Injection-related
 7. Abandonment
 8. Emotional trauma
 9. Radiation burns
 10. Transfusions
 11. Billing problems
 12. Failure to refer
-

doctrine can best be summarized as a requirement that a physician explain to his patient all reasonable dangers and all reasonably accepted medical and surgical alternatives. It is a matter of communication — of advising the patient of his options. A patient has an absolute right to his own decisional process and must be given the facts and your recommendation in order to make an enlightened choice.

The proof of informed consent can best be noted by making an entry on the chart, such as, "Hazards, risks and acceptable alternatives explained and offered. The patient agrees with my recommendations." When the question involves a surgical procedure or a drastic procedure, it is often wise to have your office nurse or the floor nurse present to note that she overheard the discussion.

Conclusion

I remain totally dedicated to the jury system and in total opposition to panel hearings or judge-only trials. Somehow, with all their faults and prejudices, a cross section of "twelve good men and true" has an uncanny way of stumbling into the right result far more often than not. They do especially well in those cases where the defense of the physician has been honest, aggressive, and locally oriented.

Some of you may feel that I departed from my assigned topic of "avoiding malpractice" by proceeding to assume that you *will* be sued and commencing my remarks from that assumption. It's just this simple . . . you've been caught up in the twentieth century phenomenon called consumerism, and you *will* be sued. So quit thinking about "legal blackmail" or putting your assets in your wife's name or countersuing, and go to work. Report the matter and then calmly review your own records, the hospital records, and your memory. Then dictate the most copious review of the case you have ever done in your life. Include everything you can remember. There is always much that never finds its way into the charts which often gives us a lead to something which may be helpful. Tell it *all*. If you were then under some outside pressure or health problem of your own, tell us about it. We need to know *now*, not half way through the trial.

Thank you for letting me share my thoughts with you. I have enjoyed being here and hope to see you again, anywhere but two places — in your office or in the courtroom.

★★★

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The American Legal System — Friend Not Foe

BURKE C. MURPHY, J.D.

Jackson, Mississippi

IMAGINE THE FOLLOWING. A patient leaves the doctor's office dissatisfied with the results of his treatment. By the time he gets home, he is even more dissatisfied, especially in light of the charge for the services, which to him is astronomical. The more he turns the situation over in his mind, the more frustrated and angry he becomes until finally, he blows his stack. He goes to his bedside table, takes a .38 caliber revolver out of the drawer, runs to his car, and drives at breakneck speed back to the doctor's office. He screeches to a halt, bolts through the front door past a waiting room full of patients, and into the doctor's office. With a scowl on his face, he empties the revolver into the doctor's chest, turns around, and walks out.

Knowing that there are many dissatisfied patients in our society, why is the above scene not a daily occurrence? Because it is not necessary. Our society has developed a better method of settling disputes. A method which in most cases, provides for reasonable, fair, and uniform settlement of disputes. We have laws; we have the American legal system.

Although there are several ways in which the law is made, two are of primary concern to the practicing physician. The first of these is statutory law, which is formulated by congress on a national level and by state legislatures on a local level. As far as malpractice legislation is concerned, it has been and probably always will be a battle fought for the most part in the legislatures of the individual states. During the malpractice "crisis" of the mid-seventies, there was a flurry of legislation in different states which did everything from shortening the statute of limitations on malpractice actions — to requiring screening prior to the filing of suits — to establishing doctor owned insurance companies.

While these laws designed to protect the medical profession were being made, others were being made to protect the patients. These were not made primarily in state legislatures but in the courts. Judicial

decisions have had just as great, if not a greater impact on the medical profession than statutes. For example, malpractice screening panels set up by state legislatures have been struck down by some courts. And in several states, shorter statutes of limitations for medical malpractice actions have been declared unconstitutional. It is safe to say that because we have judicial review of our legislative actions, there have always been and there always will be changes in the law.

"It's not perfect, but it's the best system we have."

Because statutes and judicial opinions are open to interpretation, there are always "shades of gray" in the law; and for this reason, we have lawyers. Before anyone criticizes the legal profession, he would be well advised to remember that for every lawyer who sues a doctor, there is a lawyer to defend that doctor. Just as physicians are needed to take care of complicated physical ills, lawyers are needed to take care of legal "ills" or torts. There was a time when an individual might have been able to successfully argue on his own behalf before a judge and/or jury. But due to the number and complexity of "laws" that we now have, a lawyer is essential. However, the volume and complexity of laws are not the only reasons lawyers are necessary. Part of a lawyer's ability to successfully handle a case depends on his ability to see his opposition's point of view, anticipate all the arguments that will be raised against him, and prepare in advance for those arguments. The lawyer's analysis of a case and the decision of the type of strategy to pursue are not unlike the physician's diagnosis and course of treatment for a patient's illness. Both are gained through a thorough educational process and even more so by practical experience. Yes, lawyers are necessary to tell an uninformed client of his remedies at law just as a physician is necessary to tell an uninformed patient of remedies for his physical problems.

Mr. Murphy is assistant executive secretary and general counsel for the Mississippi State Medical Association.

Because there is room for disagreement as to laws and the interpretation of laws, we have a judicial system known as the adversary system, which is patterned after the English legal system. The adversary system is based on the fundamental idea that it is no sin to disagree. Knowing that men will always disagree, there must be provided some reasonable, fair, and uniform method of settling these disagreements. The person presiding over this adversary system is the judge. He is required to rule on points of law during the course of a trial. In jury trials (which is how almost all medical malpractice cases are tried) he is required to instruct the jury as to what laws must be followed in arriving at their decision. The rulings of the judge, both on legal questions raised during trial and on questions regarding his instructions to the jury are final and may be questioned only in an appeal to a higher court. The trial judge (in Mississippi) even has the authority to render a "judgement notwithstanding the verdict," which means he can reverse the jury's decision if he feels that it is improper or was not warranted by the evidence presented. This ruling also is final unless appealed.

The jury is used in our adversary system as the trier of fact. A Mississippi jury is composed of twelve individuals who are picked from a large group by a process known as *voir dire*. During *voir dire*, the judge and the attorneys question prospective jurors to make sure none of them have any preconceived ideas about the matter to be tried. Both the plaintiff and the defendant have a certain number of challenges which can be used to "scratch" a prospective juror. After challenges have been used, a jury is seated and sworn to try the issues. In a malpractice case, nine of the twelve must agree on a verdict (unlike a criminal case which requires all twelve to agree).

Our judicial system, even though it has its weak points, usually arrives at a fair result. The adversary system gives everyone their "day in court" and allows decisions of fact to be made by impartial laymen. Often, it seems unusually slow and quite burdensome to the participants. But in the end result, it is a much better way to settle disputes than any other method. So, one of these days when you are sued for malpractice, don't get mad at the plaintiff's lawyer or gripe about the judge and jury. After all, our legal system is necessary to prevent chaos.

It's not perfect, but it's the best system we have. Certainly it's better than the scenario described earlier of settling grievances on a personal, sometimes violent, basis.

★★★

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Malpractice: A Need to Understand The Rules

C. G. SUTHERLAND, M.D.

Jackson, Mississippi

IN FEBRUARY 1980, it was my privilege to attend a two-day seminar of the American Trial Lawyers Association meeting in Boca Raton, Florida, one of several seminars held each year throughout the country by ATLA. A conservative estimate would place between two and three hundred lawyers in attendance, of whom the vast majority were plaintiffs' lawyers. Speakers came from all over the United States — Florida, West Virginia, New Jersey, New York, Pennsylvania, Massachusetts, Connecticut, Maine, Illinois, Michigan, California, Texas and Louisiana — and included private practitioners as well as university law professors. Every presentation I heard was aimed at improving the plaintiff's chances toward a favorable resolution. Continuing education credit was given to those lawyers who desired it.

The program included presentations of the following subjects: "How to Read a Hospital Chart and Records," "Emergency Room Medicine," "Neurosurgical Injuries," "Soft Tissue Injury Cases," "Use of the Psychologist as an Expert Witness," "Preparing the Plaintiff to Testify," "Structuring Your Case Through Pre-Trial Planning," "Handling Rural Juries," "Demonstrative Evidence."

The quality of this program was impressive. These plaintiffs' lawyers obviously mean business in better preparing themselves to sue doctors for malpractice. The speakers were excellent and obviously well informed. Educational aids included slides, cassettes, video-cassettes, demonstrative evidence (anatomical drawings, charts, etc.), and an exhibit of a complete set of medical/legal textbooks written for the legal profession.

In addition, the ATLA keeps its members informed via membership publications of the various malpractice activities (laws, trial decisions, etc.) that go on all over the country. They have access to physicians over the United States who are available

to review a case for possible malpractice action, and who are willing to testify in court. In short, I left the meeting with the impression that the ATLA is an intelligent, articulate, highly organized, dedicated group of plaintiff lawyers — with much of that dedication being directed towards the defeat of the defendant doctor in a malpractice suit.

The malpractice plague of the mid-seventies, which showed signs of abatement, now shows signs of revitalization. Many of the statutes that were passed in an attempt to bring order out of the malpractice crisis have not stood the test of challenge and have been declared unconstitutional. Plaintiff lawyers are proving adept at innovative theories that extend the risk of malpractice actions. Both jury awards and settlements have reached a record high and promise to go higher. In Mississippi, during the past six months, one malpractice case was settled for over a million dollars and one jury award was for \$750,000 — both records for this state.

If Mississippi physicians are to improve their posture in the malpractice arena, they must become better informed as to what constitutes medical and legal malpractice. Actually, the time spent in this regard would be much less than the time you would spend if you were sued and the case taken through a court trial. If we would learn the basics — and you do not need to have a law degree — and strive for a reduction of the *possibility* of a malpractice action against us, it would be time well invested. None of us are immune to the possibility of a malpractice lawsuit.

MMFES and MSMA are working together to develop an educational program concerning malpractice. At present, we have a one-hour video cassette program, produced by the Florida physician-owned malpractice insurance company, that is an excellent start in this direction. MMFES will be happy to present this program, anywhere in the state, upon request of any interested group of physicians. In addition, MSMA and the Mississippi State Bar

(continued on page 196)

Dr. Sutherland is medical director of the Mississippi Medical Fraternal and Educational Society.

Preparation for Testimony in a Malpractice Case

C. R. MONTGOMERY, J.D.

Canton, Mississippi

ONCE A LAWSUIT HAS BEEN FILED and the insurance carrier, attorneys and defendant doctor have made the decision to defend the claim or lawsuit, there are several considerations a physician must be aware of in dealing with the dilemma of litigation and in preparing to be an effective adversary.

First, the doctor must accept that the procedures of pre-trial, trial of the case, and post-trial hearings and appeals are completely contrary to his training and custom and practice. Entering the "adversary arena" produces both frustration and satisfaction. Within the system the plaintiff and his attorneys are determined to intimidate, frustrate and defeat the defendant doctor, and in the process, obtain a sufficient amount of money from the doctor and his insurance carrier. The doctor who understands this situation quickly develops the mental toughness to begin preparation for his defense.

Second, the doctor, although accustomed to lingering illnesses with patients, must realize also that preparation, trial and post-trial procedures may last from six months to four years or longer. The defendant must be prepared to cope with sudden emergencies for information, depositions, appearances, and long indefinite waits for progress or trial. Delay in trial dates especially frustrate doctors and attorneys; however, the defendant doctor must be positive and relentless in his attitude that he can cope with and prevail in the "adversary system."

Third, the defendant doctor must be convinced of his cause and position in the premises. Ample opportunity will be given to the defendant doctor to review all applicable records, read testimony of other witnesses, and consult with physician colleagues and other experts. A doctor's commitment to the belief that his actions or lack of actions met the standard of care under the circumstances will serve him well throughout the ordeal of litigation and will be evident to the plaintiff's attorneys, judge and jury.

Mr. Montgomery is a practicing attorney in Canton, MS, and is general counsel for the Mississippi Medical Fraternal and Educational Society.

Pre-trial Preparation

After the lawsuit has been filed, there should be another evaluation of the case by carrier, doctor and defense attorneys. If the review sustains the original decision to defend, counsel and the defendant doctor must begin immediately the most important part of the adversary system, preparation. The single factor contributing to most defeats in trial, regardless of the merits of the case, is lack of pre-trial preparation or the wrong type of preparation.

The doctor should be aggressive in his own defense. Immediately after the claim or suit is filed the doctor should locate and make available all personal and institutional records relative to the alleged incident. Additionally, the doctor needs to assist in identifying all parties who may contribute to the trial by testimony, such as nurses, orderlies, persons who checked the patient in at the emergency room, former doctors, and other parties. After all records are obtained the defendant doctor should transcribe or explain the records in writing, so that laymen attorneys and other members of the defense staff may understand and appreciate the procedures and significance of the treatment provided to the patient.

After the testimony of contributing witnesses has been verified by deposition or interrogatories, and lawyer and doctor agree on the contents and import of the records, the attorney and doctor develop the "theory of the case." The theory of the case must be consistent with the facts and understandable to the jury; and the defendant doctor must be completely comfortable with it.

The event in the preparation for a trial which causes the most consternation among defendant doctors is the deposition. Federal and state statutes allow plaintiffs and defendants to examine opposing parties or witnesses under oath before a court reporter. After completion the deposition may be used for impeachment purposes, or in the event of death, disability or unavailability of the party deposed, for testimony. The plaintiff's attorney and oftentimes

(continued on page 196)

Mississippi Medical Fraternal and Educational Society

CHARLES M. "CHUCK" DUNN

Jackson, Mississippi

IN RESPONSE TO the malpractice crisis that occurred in the mid-seventies, which was accompanied by an astronomical increase in malpractice premiums, a committee of the Mississippi State Medical Association investigated the feasibility of establishing a "captive" insurance company to provide professional liability insurance to Mississippi physicians. Under the sponsorship of MSMA, such a company was organized, and in March 1976, the Mississippi Medical Fraternal and Educational Society (MMFES) officially came into being. The Society is a non-profit corporation organized under the laws of the state. Initial capitalization for the corporation came from voluntary membership dues. Today, more than one thousand physicians enjoy coverage from MMFES, and the Society enjoys sound financial stability.

MMFES is a separate legal entity for the Mississippi State Medical Association, and even though cooperation and exchange of ideas are freely employed, neither organization is bound by the other. An annual meeting is held in conjunction with the annual session of the Mississippi State Medical Association for the purpose of electing directors and furnishing to the membership information on the Society's financial condition.

The Society is administered by an elected Board of Directors, who are responsible to the membership. There are nine directors, elected to staggered three-year terms. The Society retains nationally recognized firms to advise the board of accounting and actuarial requirements.

A full-time general manager and staff are responsible for the overall functioning of the Society on a day-to-day basis. The staff is assisted by legal, accounting, and actuarial experts.

The general manager, responsible to the Board of Directors, oversees activities of the Society in the areas of marketing, underwriting, bookkeeping, establishing risk reserves, and coordinates legal, accounting, and actuarial activities.

He and his staff are also responsible for investigating incident reports, claims, and lawsuits, and gathering material for the consideration of the Claims and Risk Management Committees. Additionally, a newsletter to the membership is published monthly.

The medical director is responsible to the board in areas more medically-oriented than organizationally or actuarially-oriented. That includes overseeing the Risk Management and Claims Committees. The Medical Director also coordinates educational efforts regarding malpractice loss prevention.

The Claims Committee reviews claims and suits with the defendant physician and makes recommendations as to whether they should be settled or litigated. This review is done in consultation with the physician involved, legal counsel, the general manager and staff, and the medical director. When the advice of physicians in specialty fields is needed, the Claims Committee may seek advice from specialty sub-committees. No claim or suit can be settled without the concurrence of the doctor involved.

The Risk Management Committee is primarily concerned with attempts to reduce the risk of malpractice claims. This committee might consult with doctors who have an undue number of complaints or claims against them, doctors who appear to be practicing substandard medicine; doctors who appear to represent an increased risk in such areas as informed consent, poor records, and poor public relations; and doctors who might be in difficulty as a result of senility, emotional problems, or chemical abuse. The Risk Management Committee reviews initial applications for insurance, when questions arise as to the desirability of issuing coverage. This committee is also concerned with the advisability of imposing surcharges in individual cases.

It has been estimated that a 10% improvement by the medical profession in identifiable areas of increased risk could well result in as much as a 50% reduction in the malpractice incident rate.

When the Society was formed, a Membership Committee, composed of approximately 30 doctors over the state, rendered an invaluable service in

Mr. Dunn is assistant general manager, Mississippi Medical Fraternal and Educational Society.

reviewing membership applications and making recommendations concerning insurability. The Risk Management Committee will likely assume more of this type of responsibility in the future, but the Membership Committee will continue to be consulted on a regular basis.

The Board of Directors has stated the following as the purposes of the Mississippi Medical Fraternal and Educational Society:

Protection of the Doctor. We live in the most litigious society in the history of the world. The chances of an individual doctor being sued at least once in his lifetime are currently about one in seven. Improvement in certain areas would reduce the chances of being sued, but it would be totally unrealistic to think that the risk could be reduced to zero. It might be said that a certain malpractice risk more or less "goes with the territory." Too many people want satisfactory results each and every time, and too many plaintiff lawyers equate "mal-results" with "malpractice." Add to this the fact that some malpractice does occur. Doctors must have professional liability insurance available.

Protection of the Patient. In a large study done in California, it was concluded that 4% of patients admitted to a general hospital would experience incidents which would be compensable should the patient choose to press the issue. Doctors are only human and can expect to make mistakes, which in judicial retrospect, might not have been made by a reasonably prudent individual. These cases should be settled if a reasonable settlement can be obtained. On the other hand, cases should not be settled merely for expediency or because it would cost more to go to court than it would to settle. Cases without significant merit should be vigorously opposed.

Improved Medical Care. Improvement can always be made. By identifying areas of substandard care, the Society can be of benefit to its members through educational programs. It has been suggested that frequently a relatively small number of physicians are responsible for an inordinately high number of claims and suits. By exercising restrained selectivity of coverage, and the use of surcharges in selected cases, the Society should be able to affect the quality of medical care that is practiced in this state.

The threat of malpractice suits is a fact of life. Every patient who a physician sees is at least a

possible future courtroom adversary should a mal-result occur, be it real or imagined. And while doctors should not live in mortal terror of such possibility, it should be acknowledged. It behooves all physicians to at least become knowledgeable in areas where the risk can be reduced.

If the Society is to be of maximum benefit to its members, the utmost cooperation of all concerned is required. An attitude of "I paid my premiums — let the insurance people handle it" is self-defeating for the Society as a whole.

A properly prepared lawsuit may take hours of preparation involving interrogatories, depositions, and pretrial conferences; however, to do less is to invite defeat in the courtroom. It has been said that 90% of a lawsuit lies in the preparation thereof. The Society feels that one of the best defenses we can employ against frivolous suits or suits with little merit is for us to win most, if not all, of them in the courtroom. There is *no* financial reward for a plaintiff or plaintiff's lawyer when they lose a suit, for the attorney's fee is generally contingent upon a successful verdict.

With these things in mind, the Society encourages prompt reporting of incidents which have a reasonable potential for future litigation. At times, with the policy-holder's concurrence, it might be possible to close a case satisfactorily before the plaintiff even goes to a lawyer. In cases of clear liability, this is a proven and economically successful claims procedure.

The philosophy of this Society is to be firm, but fair. There are no decision problems in cases of obvious malpractice or obvious lack of malpractice, however, there is a large gray area that exists in which even experts may disagree. In this area, the final question of malpractice will be determined by the judge or the jury. As one plaintiff's attorney said, most cases of this sort have "something," in retrospect, that is favorable to the plaintiff. What he wants to know, however, before he takes the case is, "how much." Remember, in civil litigation, the plaintiff must carry the burden of proof.

The Board of Directors of MMFES is hopeful that, as a result of the philosophy and activities outlined above, the Society will effectively serve its members as they strive to provide their patients the best medical care available. ★★★

P.O. Box 4625 (39216)

Understanding the Malpractice Rules / *continued from page 192*

Association are planning a joint medical-legal seminar within the next several months.

Most of your insurance premium is paid in order to protect you financially if a malpractice suit is filed. This would include settlement if such is elected, as well as defense of the case and payment if there is a judgment against you. Very little of the premium dollar is spent in educational efforts to reduce the possibility of malpractice — and yet prevention could be of enormous benefit in controlling and reducing the cost of malpractice insurance.

In discussing the matter of becoming more knowledgeable in this area, one of our members observed

that his personal interest in this regard lies about halfway between his enthusiasm for making out a will and his enthusiasm for planning his own funeral. This attitude is understandable, but so is the fact that an actuary has no difficulty determining the yearly cost of insurance premiums based on prior lawsuits — and yearly premiums have exceeded \$30,000 in some parts of this country.

Seemingly, it would behoove the members of the medical profession to learn to play the malpractice game — but you can't play the game unless you understand the rules. ★★★

P.O. Box 4625 (39216)

Preparing the Doctor for Testimony / *continued from page 193*

the plaintiff are present in the room during the taking of the deposition; the defendant doctor is represented by counsel, and other resource people may be available. For the first time the plaintiff's attorney has an opportunity to make inquiries of the defendant doctor regarding all aspects of the case.

Your attorney may make suggestions for you to follow in giving a deposition, such as: always tell the truth; think before you speak; never volunteer information; if you cannot recall, don't hesitate to say so; avoid using superlatives such as "I never" or "I always"; take all the time necessary to examine a document or item presented to you for identification or explanation; don't let the opposing attorney put words in your mouth; and don't express anger, argue, or make attempts at levity.

The Courtroom

After completion of pre-trial investigation, discovery and pleadings, the lawsuit comes to trial. The defendant doctor must at that time review his records and all depositions, read all pleadings filed, and consult for the last time with his attorneys. At this time the attorney may make suggestions to the defendant doctor for appearance in the courtroom, such as:

- (1) Be prepared to be available in the courtroom during the progress of the trial, although it may last several days.
- (2) Avoid displaying evidences of wealth such as unusual clothing, cars, glasses, and jewelry.
- (3) Do not express arrogance, bitterness or defensiveness about the case. The defendant doctor should show the same sympathetic concern for the patient

that he had before the individual became the plaintiff.

(4) Be aware that the first witness at trial often is the defendant doctor, called first by the plaintiff's attorney as an adverse witness.

(5) While the jury is being selected, and after final selection, take great care in appearance, manner and remarks — both inside and outside the courtroom.

(6) Do not show emotion, facial expressions, smile, or laugh at testimony and statements given by other witnesses or attorneys. Don't take extensive notes, and devote your full attention to the proceedings. Also, speak loudly enough so that the judge and jurors may hear clearly. Look at the jury while you are talking.

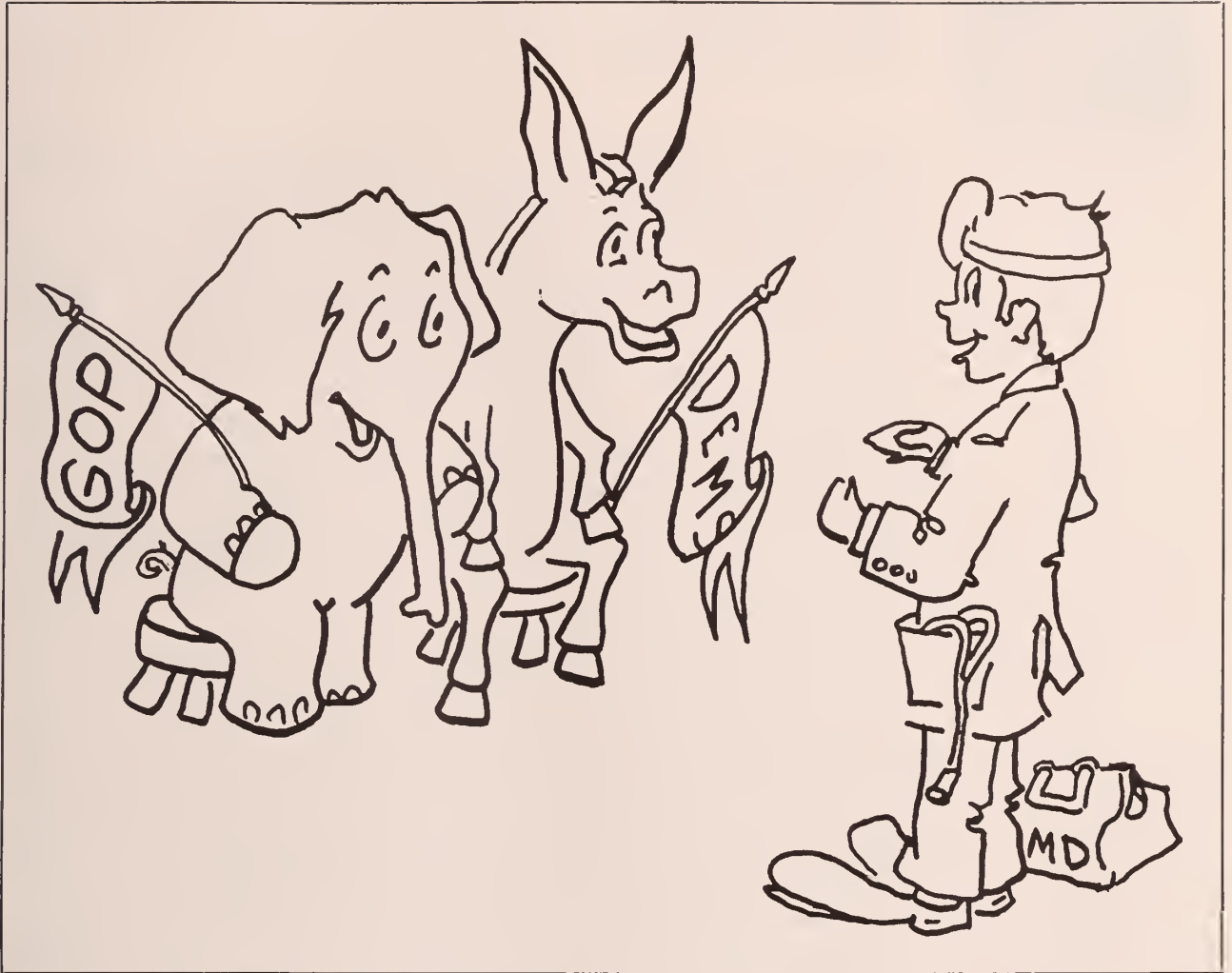
(7) Avoid any reference to insurance, and do not answer questions in this regard until you have given your attorney time to object.

(8) Do not show exasperation, boredom or fatigue. The plaintiff's attorney will willingly and knowingly provoke your patience and challenge your intelligence.

Conclusion

The defendant doctor best prepared to deal with the ordeal of litigation is the defendant doctor who is committed to his position, who assists in the preparation of his defense, and who exhibits in the courtroom that quality of modest courtesy usually associated with integrity and competence. ★★★

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The President Speaking

Voice of Organized Medicine

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

From July 19-24 I had the opportunity to attend the Annual Meeting of the AMA in Chicago. I must hasten to add that this was my very first AMA convention to attend. As there are no medical education seminars presented at the Annual Meeting, I had thought there wasn't much to see or do at these meetings; but this year, as president of MSMA, I felt it was my duty and responsibility to attend and to see first hand just what goes on. MSMA was represented by Delegates Weems and Gilmore and Alternate Delegates Stanley Hill and Ed Hill.

I have never been more pleased and satisfied. I believe I can truthfully say to you that the leadership of the AMA has its head on right and the AMA once again is the true spokesman for organized medicine. I honestly believe that American medicine has never been better, nor has it been in better hands.

The House of Delegates is composed of 285 members. Of these, 215 are from state associations, 57 are from national medical specialty societies, eight are from resident physician, student business and medical school sections, and five are from the military services. Even though some of these groups are small in number, they are loud once they get the mike on the floor of the House of Delegates. I was impressed with the delegates. Especially was I impressed when I tried to reflect just how much time these servants had spent doing their homework. It is truly amazing just what does and does not turn an individual on when any particular resolution is presented. Invariably, as one sits and listens, someone will eventually say what you were thinking. The representation that we have at the present time is what has altered the path of the AMA. Of course, we could and should say that some alteration has probably been brought about by changing times. We must all be alert to what causes change. We must get more and more active in our local medical societies, always sending good delegates to the state convention. Then, there is no way a so-called misdirected delegate can reach Chicago to represent you on the national level.

We must increase our membership in our state and national societies. We must speak through strength and actions. Numbers will help us with both. We must also enlist the help of our wives to a greater degree. We must never underestimate the power of our spouses. See that your wife is a member of the Auxiliary by paying her dues along with yours. If your group has some single guys, help them find a bride. Ha!

I would also like to urge all of you to sign up for the Political Action Committees sponsored by the AMA and MSMA-AMPAC and MPAC. I do believe that this is one of the most profitable ways you could spend a few dollars. We must be in politics because politics and legislation has an influenced for better or worse on our medical practice. I still believe, just as you, that medical people know a heck of a lot more about what the American public needs in the way of medical services than do politicians and government agencies. However, if we do not speak up and let our presence be known in the political process, how will anyone find out?

While recuperating from minor surgery for a few days, I saw television ads for a program called "Speak Up America." It occurs to me that our motto should be "Speak Up Medicine," and let's keep the good medicine rolling! In the next issue of the JOURNAL we will print the Republican and Democratic platform health planks, with some comments. I urge you to read this for even more of an indication of why we need an AMA and active participation by all physicians and their spouses in the political process.

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

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Nation Must Set Priorities

On Tuesday evening, August 12, Ted Kennedy gave his address to the Democratic Convention. He was awarded a standing, rousing, and lengthy ovation by the delegates. Several proclaimed it his greatest speech ever; even the commentators seemed impressed; and John Anderson, on "Meet the Press," referred to it as Kennedy's "great and inspiring speech, in that it gave hope."

Advocating National Health Insurance, big spending for jobs, increased benefits for welfare — in short, spending our way out of all our problems, he guaranteed not life, liberty, and the *pursuit* of happiness, but life, liberty, and happiness for all our people.

It is somewhat comforting to know that he was rejected in his bid for his party's nomination as their presidential candidate; but it is difficult to understand such liberalism at a time when we are flirting with economic disaster. Such proposals as Senator Kennedy's certainly sound fiscally irresponsible.

If this is not enough to be concerned about for the future of our country, consider the presidential committee's "Doomsday Report": in twenty years a world population of 6.5 billion as compared to the present 4.5 billion. Surely we cannot blindly ignore that which, if we don't have a change in direction, is inevitable. Even in these United States we are approaching a limit to the food production our present day technology is capable of achieving.

While we should consider ERA, the poor, the armed forces, government employees, union workers — yes, and even medical care — we need to set our priorities; and the first should be the preservation of the nation and government. To preserve the free enterprise system we will slowly have to decrease deficit spending, decrease the money supply, and decrease our regulatory policy.

Big government is necessary in this day and age, but our system cannot survive without a change in direction. Our leaders must educate the public to the

dangers of overpopulation, even more than to the hazards of cigarette smoking or the danger of saturated fatty acids.

W. MONCURE DABNEY, M.D.
Editor
Crystal Springs, MS

GUEST EDITORIAL:

It Can Happen Here — and It Did!

When asked to write about how it feels to get sued for malpractice, I immediately assumed that meant a recital of all the subjective sensations, rather than opinions on the whys and wherefores of a suit. May I assure you there were a plethora of feelings — deep, soul-shaking ones! I think I know now what clogged my carotids!

When you have given 40 years to your practice and to your patients, trying to do your best and thinking that was quite adequate, you are shaken with disbelief and disappointment as you read all the things you allegedly did wrong or didn't do at all in this instance.

It is a chastening experience to pick up the telephone and call Mike, the general manager of MMFES, to inform him that you are his next client, still stunned that this is really happening. I can assure all members of MMFES that they are in "good hands," for Mike's competence comes across as he tells you in your ignorance exactly what to do next. This is most reassuring, and reassurance is just what you need about then!

Your next ego-straining act is to sit before the claims committee and try to explain how you got there. Some reasons you know, and some you don't. You soon learn the true meaning of "devil's advocate." You don't know whether to be mad, sad, or glad as they ply you with questions. You finally realize the necessity, and know that they will do right by you.

IT CAN HAPPEN HERE / Continued

Having decided to fight your case, the next extremely reassuring act is the choice of attorneys by MMFES. After your first conference with counsel, you even begin to think that maybe the world really isn't about to come to an end.

Your attorney and Mike guide you through the taking of depositions, with all the trappings of the courtroom except judge and jury. The wet palms and the hollowness deep in your chest finally disappear during the endless questioning.

A court date is set, steadily nearing. A numbing dread appears as the uncertainty of a jury's decision hangs over you. Your bravado fades, even though your confidence in your attorney and your case remain. Secretly, you pray for a settlement as the specter of financial ruin hovers over you. Anticipating the trauma of the courtroom, your dread increases. You want to do the right thing, not turn and run, not stick the Society, not let yourself or your profession down.

When my phone rang — "we've decided to settle, if it's all right with you," all my secret prayers were answered, and the ball of fear dissipated in a sudden surge of relief!

So, hearken to all the warnings issued by MMFES. You want to avoid your own replay of the above at all costs!

ARTHUR A. DERRICK, M.D.
Durant, MS

Medico-Legal Brief

Suit for Advising No Malpractice

A trial court erred in ruling in favor of a physician on a claim of negligence in offering a consulting opinion, a California appellate court ruled.

A patient suffered partial paralysis after an automobile accident in 1962. After two operations on her back, she began seeing an orthopedic surgeon. By March 23, 1968, he had performed five operations on her right leg and four operations on her left leg, necessitating hospitalization on 11 occasions. Shortly afterwards, she came under the care of another orthopedic specialist, who recommended amputation of her right leg in February 1969. After the amputation, she consulted a law firm about a possi-

ble malpractice action against the orthopedist who had performed the nine operations.

The firm conducted a detailed investigation, including obtaining her hospital records and the records of the orthopedists, hospitalizations and treatment. The firm contacted three local orthopedists, who declined to get involved. It finally found an orthopedic surgeon who was willing to act as a consultant. After he reviewed all the records, he advised the attorneys that the orthopedist had conducted himself within the standard of care.

The attorneys then advised the patient that she did not have a malpractice cause of action and no further action was taken. By February 1970, the statute of limitations had expired on the patient's claim against the operating physician.

Later, in the summer of 1970, one of the attorneys learned that another attorney had a number of malpractice suits pending against the initial orthopedic surgeon. That attorney then filed suit against the initial orthopedist. The suit was dismissed as barred by the statute of limitations. The patient then filed suit against the consulting orthopedist.

At the trial, three medical experts testified that the physician's care and treatment of the patient was negligent and was the cause of the amputation of her leg. The operating physician testified that his surgical privileges were revoked on June 4, 1970, and that his use of drugs in the years 1965 through 1968 may have affected his judgment. He also admitted that he had performed several of the operations in a manner below the standard of care.

A trial court granted a nonsuit on the claim of fraud and entered judgment on a jury verdict in favor of the consulting physician. Reversing the decision, the appellate court said that the case should have been submitted to the jury. The evidence of malpractice on the part of the treating physician was sufficient to find that the consulting orthopedist had knowledge of the falsity of his representation that the treating physician's actions were satisfactory, the court said.

The trial court erred in giving an instruction on proximate cause because either the negligence of the consulting physician or of the patient's first attorneys could have caused the same result. The court should have instructed the jury on legal cause and used a substantial factor test. Any intervening negligency by the attorneys would not relieve the consulting physician of liability for negligence, the court concluded. — *Hart v. Browne*, 163 Cal.Rptr. 356 (Cal.Ct. of App., March 31, 1980)

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MSMA Board of Trustees Conducts Summer Meeting

MSMA's Board of Trustees held its regular summer meeting on July 31-August 1 and considered a full agenda of business including referrals from the May meeting of the MSMA House of Delegates and other special reports.

In a special study of the current status and role of "physician extenders" resulting from a resolution adopted by the House of Delegates, the Board adopted the following policy statement: "The Board is opposed to the practice of medicine by anyone who has not met requirements to be licensed to practice medicine in Mississippi; the Board is aware and deeply concerned about the shortage of registered nurses in Mississippi; the Board supports efforts to train more registered nurses and the Board is opposed to changing the status of registered nurses to that of nurse practitioners; and the Board strongly encourages registered nurses and other limited practitioners who have an interest in practicing medicine to enter and graduate from medical school."

In other actions the Board approved a plan to update the *MSMA History*. This will be the third history published by the association, and will cover the years 1949-1980. The two earlier volumes cover the periods 1856-1910 and 1911-1949.

The Board also reviewed statements from the state's congressional delegation in response to a call from the association for a congressional review of the Federal Community Health Centers and National Health Service Corps programs "in light of these programs" apparently uncoordinated and at times wasteful expenditures of federal health funds in the name of providing 'primary health care' to so-called underserved health areas in Mississippi." The Board urged members of the association to document and write the state's congressional delegation regarding the cost of, need for, and continuity with existing health services of federal health centers in their areas.

The Board reviewed and concurred with plans of the Mississippi Foundation for Medical Care-PSRO to assume review authority over physicians' services in hospitals placed on prepayment review (i.e. non-delegated hospitals). The Board further urged that such review include physicians' services in all hos-

pitals where indicated.

The Board considered recent cutbacks in the Mississippi Medicaid program and went on record in opposition to arbitrary limits on Medicaid required services such as hospital, nursing home and physician services. The Board noted that the association was in favor of some type of co-payment on all Medicaid optional services as opposed to required services.

In reviewing plans for MSMA's 113th Annual Session (1981) the Board concurred with a recommendation from the Council on Scientific Assembly that beginning in 1982 the annual session be conducted in May on a Thursday through Sunday format. The recommendation will be presented to the House of Delegates at next year's meeting.

The Board noted plans for the MSMA president and president-elect to meet with their counterparts in the Mississippi Bar Association to discuss areas in which the two associations might work together for better interprofessional cooperation. Plans to discuss an MSMA-Mississippi Trial Lawyers' Symposium on Malpractice were also reviewed.

Recent changes in the AMA "Principles of Medical Ethics" were reviewed, and the Board approved submission of a resolution at the December 1980 meeting of the AMA House of Delegates which would recognize advertising as demeaning to the profession and call on the AMA to continue to seek legal remedies.

The Board reviewed the status of the MSMA/AMA Jail Project and heard a report on plans to strengthen the Mississippi Medical Political Action Committee.

The Board met in Natchez for its summer meeting at the invitation of the Homochitto Valley Medical Society. MSMA Board members and officers attending the meeting were: Drs. Paul H. Moore, president; R. Faser Triplett, president-elect; Gerald P. Gable, immediate past president; J. Elmer Nix, secretary-treasurer; Carl G. Evers, speaker, house of Delegates; Walter H. Rose, vice speaker, House of Delegates; Sidney O. Graves, Jr., chairman, Board of Trustees; Whitman B. Johnson, Jr., vice chairman; W. Boyce White, secretary; W. Joseph Burnett; William C. Gates; William B. Hunt; Ellis M. Moffitt; James O. Manning; George L. Arrington, Jr.; and W. Lamar Weems, delegate to AMA.

Council Announces Meeting Schedule For 113th Annual Session

During a recent meeting to plan MSMA's 113th Annual Session, set for April 26-30, 1981, the Council on Scientific Assembly scheduled individual meetings of the 14 scientific sections.

In voting to discontinue the combined section meetings — the format used in planning the recent 112th Annual Session — the Council urged all of the sections to present at least one scientific program of general interest. The Council also suggested that each section meet in conjunction with its respective specialty society when possible.

According to Dr. J. Elmer Nix of Jackson, chairman of the Council, business and scientific meetings for the 1981 Annual Session will be conducted according to the following schedule:

Sunday, April 26 — (morning) Sections on Anesthesiology, Pathology, Orthopedic Surgery, Psychiatry, Radiology, EENT, Dermatology and (afternoon) Mississippi Medical Fraternal and Educational Society's annual membership meeting;

Monday, April 27 — (morning) MSMA House of Delegates and (afternoon) Reference Committees of the House of Delegates and annual membership meeting of the Mississippi Foundation for Medical Care;

Tuesday, April 28 — (morning) Section on Medicine and (afternoon) Sections on Surgery, Radiology, Urology and Preventive Medicine;

Wednesday, April 29 — (morning) Section on Family Practice and (afternoon) Sections on Ob-Gyn and Pediatrics; and

Thursday, April 30 — (morning) House of Delegates.

The Council planned golf and tennis tournaments on Tuesday afternoon and a fishing tournament on Tuesday and Wednesday.

An association dinner on Wednesday evening will feature Abigail Van Buren (Dear Abby) as guest speaker. Medical alumni functions will be conducted on Monday evening.

The Council recommended that the James Grant Thompson Memorial Lecture be rotated between the Sections on Medicine, Surgery and Family Practice, and that the first lecture be presented at the Section on Family Practice meeting, April 29. The Council also approved a recommendation to the House of Delegates that future annual sessions be held on Thursday through Sunday.

In addition to Dr. Nix, members of the Council on Scientific Assembly are: Drs. David Carlson and Orin Guidry of Jackson, chairman and secretary, Section on Anesthesiology; Drs. Thomas Garrott of Biloxi and Donald F. Barraza of Natchez, chairman and secretary, Section on Dermatology; Drs. J. George Smith of Jackson and W. Joe Burnett of Oxford, chairman and secretary, Section on EENT; Drs. Frank W. Bowen of Carthage and W. K. Stewart of Pass Christian, chairman and secretary, Sec-

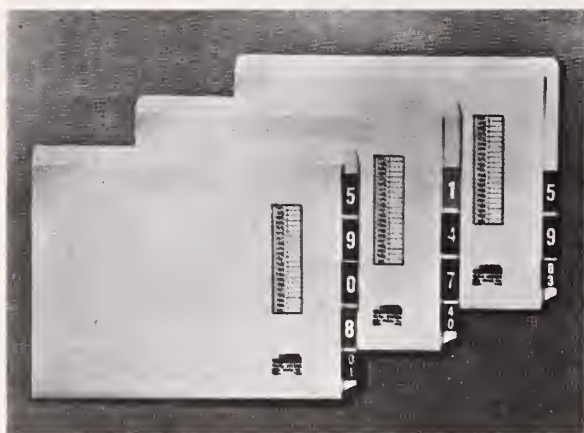


Members of the Council on Scientific Assembly discuss plans for the 113th Annual Session during a recent meeting at MSMA headquarters.

tion on Family Practice; Drs. Richard M. Nowell and Don Q. Mitchell of Jackson, chairman and secretary, Section on Medicine; Drs. Lewis Lipscomb of Jackson and W. L. Kahlstorf of Tupelo, chairman and secretary, Section on Ob-Gyn; Dr. James L. Hughes of Jackson, chairman, Section on Orthopedic Surgery; Drs. Benella Oltremari of Greenville and Thomas Puckett of Hattiesburg, chairman and secretary, Section on Pathology; Drs. Mary J. Ward of Corinth and William B. Simmons of Meridian, chairman and secretary, Section on Pediatrics; Drs. Steve L. Moore of Jackson and Thomas E. Waller of Starkville, chairman and secretary, Section on Preventive Medicine; Drs. Steve Smith and Nan Brantley of Jackson, chairman and secretary, Section on Psychiatry; Drs. Vann Craig of Natchez and Jerry Adkins of Biloxi, chairman and secretary, Section on Surgery; Drs. Kenneth Carter and Sandra Rhoden of Jackson, chairman and secretary, Section on Radiology; and Drs. Stanley Wade of Meridian and Ronald Brown of Gulfport, chairman and secretary, Section on Urology.

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AMA House of Delegates Considers Full Agenda

Major actions taken by delegates to the AMA House of Delegates meeting July 20-24 in Chicago included:

Elected Dr. Daniel T. Cloud of Phoenix as president-elect;

Adopted new ethical guidelines, the first revision of the principles since 1957;

Reiterated the AMA's current policy on national health insurance;

Urged an end to the current dual certification of continuing medical education programs;

Opposed federal subsidies giving HMOs an unfair advantage over other delivery programs;

Agreed to work for equitable and realistic reimbursement levels for physicians under Medicare and Medicaid;

Supported efforts to ease restrictions on the availability of CT scanners;

Emphasized the need for expanded AMA membership and lifted the moratorium on adding specialty society representatives in the House;

Rejected a request from the American College of Surgeons to withdraw its representative in favor of seeking continued dialogue on the problem;

Urged a "go slow" policy on mandatory pro-



Dr. Lamar Weems of Jackson, left, and Dr. James O. Gilmore of Oxford, MSMA's delegates to the AMA, prepare for the opening session of the House of Delegates during the recent annual meeting in Chicago.

grams for continuing medical education and recertification programs;

Supported a government-conducted scientific study of chiropractic;

Criticized some policies of the Joint Commission on Accreditation of Hospitals.

Reaffirmed its long-standing anti-smoking position and urged improved health insurance coverage for treatment of alcoholism;

Adopted a Judicial Council report stating that physicians should not be participants in any legally authorized execution.



Members of the Mississippi delegation discuss reports and resolutions prior to Reference Committee hearings at the July meeting of the AMA House of Delegates. From left are: Dr. James O. Gilmore, delegate; Charles L. Mathews, MSMA executive secretary; and Dr. Paul H. Moore, MSMA president.



AMA delegate Dr. Lamar Weems, center, prepares for Reference Committee hearings with alternate delegate Dr. Stanley A. Hill of Corinth, left, and Ben P. Folk, III, of Jackson, delegate to the Student Business Section.

PERSONALS

CORRECTION — In the July issue, HELEN B. BARNES, whose office for the practice of obstetrics and gynecology is located at 2915 North State Street in Jackson, was erroneously identified as a new associate of FRANK GARBIN of Ocean Springs. The Journal regrets this error.

WILLIAM M. ADEN of Jackson announces the association of JOHN B. MILAM for the practice of pediatric ophthalmology.

HOLLAND M. ADDISON, JR., and JOHN R. PIEKLIK have joined Jackson Medical Associates, P. A., for the practice of internal medicine.

BRUCE E. ATKINSON of Amory announces the association of ROGER D. RATLIFF for the practice of internal medicine.

JOE BAILEY of Tupelo was chosen "Physician of the Year" by the employees of the North Mississippi Medical Center.

THOMAS BARKLEY has joined THOMAS A. SHANDS in the practice of internal medicine in New Albany.

G. WILLIAM BATES of UMC presented a postgraduate course sponsored by the American Fertility Society in Colorado Springs, CO, in July.

WILLIAM E. BECKMAN, III, has joined GEORGE BALL, KENNETH PITTMAN, C. JAMES LEWIS, JR., FRANK R. BANKS of Jackson for the practice of obstetrics and gynecology.

GEORGE W. BYRNE of Pass Christian announces the association of DAVID E. BYRNE for the practice of general and vascular surgery.

L. T. CARL of Jackson announces his retirement from the practice of internal medicine.

MILAM S. COTTEN of Hattiesburg announces the relocation of his office for the practice of ophthalmology to 710 South 28th Avenue.

DAVID A. deBESSONET of Picayune announces the opening of a new office at 908 Sixth Avenue for the practice of urology.

EDGAR DRAPER of UMC recently delivered several lectures at the University of Hawaii.

W. MEL FLOWERS of UMC attended a recent meeting of the Board of Trustees of the American Society of Nuclear Medicine in Detroit, MI.

PERSONALS / Continued

HUGH A. GAMBLE, II, has affiliated with the Gamble Brothers and Archer Clinic in Greenville for the practice of thoracic and cardiovascular surgery.

ROLAND P. GUEST and SAMUEL C. PACE have become associated with Internal Medicine Associates of Tupelo, Ltd. Dr. Guest will practice cardiology and Dr. Pace will practice internal medicine.

WILLIAM H. GULLUNG, III, announces the opening of his office for the practice of dermatology at 405 South 28th Avenue in Hattiesburg.

BOBBY HEATH of UMC presented a paper at the recent World Congress of Pediatric Cardiology in London.

PATRICK G. McLAIN of Vicksburg announces the association of JAMES W. COOK for the practice of ophthalmology.

JAMES N. McLEOD of Jackson announces the association of E. P. SUDDUTH for the practice of internal medicine.

PAUL H. MOORE, JR., of Pascagoula has associated with Singing River Radiology Group, P. A.

NORMAN C. NELSON of UMC was guest speaker at the recent 46th Annual Conference of the Mississippi Hospital Association.

JOHN M. PURVIS has associated with Central Orthopaedic Clinic, P. A., in Jackson, for the practice of general and pediatric orthopaedics.

KENNETH J. REID, JR., has associated with Rush Medical Group in Meridian for the practice of pediatrics and adolescent medicine.

WILLIAM F. REID has joined Drs. CALLAHAN, BOONE and GREER of the Internal Medicine Clinic in Meridian for the practice of internal medicine and pulmonary diseases.

CHARLES S. RHEA, JR., has associated with WILEY C. HUTCHINS for the practice of orthopedic surgery at 1001 Main Street in Columbus.

SPENCER L. SCHREITER has joined North Mississippi hematology and Oncology Associates, Ltd. of Tupelo (JOHN C. HALBROOK and CHARLES W. MONTGOMERY) for the practice of hematology.

A. L. SIMMONS has associated with The Children's Clinic in Jackson for the practice of pediatrics.

CAROL ANN SMITH of Biloxi was recently elected president of the Mississippi Chapter of the American College of Emergency Physicians.

WILLIAM R. STEWART has joined Orthopedic Specialists, Ltd. of Jackson (GEORGE W. WHARTON and J. PATRICK BARRETT) for the practice of pediatric orthopedics and spinal deformities.

WILLIAM B. STRONG, JR., will practice anesthesiology in Hattiesburg in association with JOHN A. McLEOD, III, JOSEPH B. McMILLON, KATHERINE S. ALDRIDGE, and JAMES R. HOUSE, JR.

ROBERT NEAL SUARES has become a partner in Gamble Brothers and Archer Clinic of Greenville.

RUSSELL S. TARVER announces the opening of his office for the practice of internal medicine at 609 Inez Street in Greenville.

CHESTER A. WEST of Gulfport announces the closing of his office for the practice of surgery.

WINFRED L. WISER of UMC served as chairman of a scientific session of the Tenth World Congress on Fertility and Sterility in Madrid, Spain, in July.

DEATHS

CAMERON, ROBERT A., Pascagoula. Born Meridian, MS, March 22, 1908; M.D., University of Tennessee School of Medicine, Memphis, 1935; interned Matty Hersee Hospital, Meridian, MS, one year; died June 25, 1980, age 72.

JOBE, LOUIS HARMON, JR., Gulfport. Born Ripley, MS, April 24, 1910; M.D., Vanderbilt University School of Medicine, Nashville, 1932; interned Harper Hospital, Detroit, 1932-34; died July 18, 1980, age 70.

JOHNSTON, HUGH HARALSON, Vicksburg. Born Vicksburg, MS, June 9, 1903; M.D., Vanderbilt University School of Medicine, Nashville, 1928; interned Vicksburg Sanatorium 1928-30; otolaryngology residency, Mayo Foundation Hospital, 1930 and 1933; died June 18, 1980, age 77.

NEW MEMBERS

FARRELL, GEORGE EDWARD, Ripley. Born Boston, MA, Nov. 19, 1923; M.D., Tufts University School of Medicine, Boston, 1948; interned Carney Hospital, Boston, one year; radiology residency, Boston City Hospital, 1949-53; radiology residency Peter Brent Brigham Hospital, Boston, 1964-65; elected by North Mississippi Medical Society.

FRYE, WYNDHAM MONTGOMERY, Greenwood. Born Dublin, VA, Dec. 8, 1942; M.D., University of Tennessee College of Medicine, Memphis, 1976; interned Methodist Hospital, Memphis, 1976-77; radiology residency, same, 1977-80; elected by Delta Medical Society.

GAMBLE, HUGH A., II., Greenville. Born Greenville, MS, Aug. 4, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned University Medical Center, Jackson, one year; surgery, thoracic and cardiovascular residencies, same, 1974-80; elected by Delta Medical Society.

GULLUNG, WILLIAM H., III., Hattiesburg. Born New Orleans, LA, Nov. 3, 1951; M.D., Louisiana State University School of Medicine, New Orleans, 1976; interned University of Texas, John Sealy Hospital, Galveston, one year; dermatology residency, Charity Hospital, New Orleans, 1977-80; elected by South Mississippi Medical Society.

HALE, T. ERIC, Hattiesburg. Born Hattiesburg, MS, Oct. 7, 1950; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; family practice residency, same, 1977-79; elected by South Mississippi Medical Society.

JAMES, EDWARD THOMAS, JR., Jackson. Born Natchez, MS, June 8, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Baylor University, Dallas, one year; orthopedic surgery residency, Dallas and Affiliated Hospitals, 1972-77; elected by Central Medical Society.

LIPTON, DAVID E., Brandon. Born New York, NY, June 8, 1930; M.D., Chicago Medical School University of Health Sciences, Chicago, 1955; interned Beth Israel Hospital, New York City, one year; orthopedic surgery residency, Malmonides Hospital, Brooklyn, 1956-57; orthopedic surgery residency, V.A. Hospital and Kings County Hospital, Brooklyn, 1959-62; elected by Central Medical Society.

LOTTERHOS, WILLIAM EAST, Jackson. Born Crystal Springs, MS, Nov. 22, 1914; M.D., University of Tennessee School of Medicine, Memphis, 1940; interned Baptist Hospital, Jackson, MS, one year; elected by Central Medical Society.

MCCLAIN, ELDON DUANE, Biloxi. Born Topeka, KS, Dec. 26, 1941; M.D., Northwestern University Medical School, Chicago, 1968; interned Presbyterian St. Lukes Hospital, Chicago, one year; pathology residency, same, 1969-73; elected by Coast Counties Medical Society.

PARKS, LEON C., Jackson. Born Pensacola, FL, Sept. 15, 1939; M.D., University of Colorado School of Medicine, Denver, 1966; interned Johns Hopkins Hospital, Baltimore, one year; surgery residency, same, 1967-68, 1970-71, 1973-75; cardiovascular fellowship, National Heart Institute, Bethesda, MD, 1968-70; cardiovascular fellowship, Texas Heart Institute, Houston, Jan-June 1977; elected by Central Medical Society.

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NEW MEMBERS / Continued

SHELTON, WALTER TOWAN, Jackson. Born Charleston, MS, April 3, 1949; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned Baylor University, Houston, one year; orthopedic surgery residency, Campbell Clinic, Memphis, 1977-79; elected by Central Medical Society.

SMITH, JASON VAN ALSTINE, Gulfport. Born New Orleans, LA, Jan. 22, 1949; M.D., Tulane University School of Medicine, New Orleans, 1973; interned and general surgery residency, Northwestern University, Chicago, 1975-76; otolaryngology residency, Tulane, New Orleans, 1976-79; elected by Coast Counties Medical Society.

SPRUILL, FAYE G., Jackson. Born Crystal Springs, MS, Oct. 9, 1934; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned University Medical Center, Jackson, one year; pathology residency, same, 1967-68; anatomic pathology residency, M.D. Anderson Hospital, Houston, 1968-69; anatomic pathology residency, Baylor University Medical Center, Dallas, 1969-71; forensic pathology residency, Southwestern, Dallas, 1971-72; elected by Central Medical Society.

SUMRALL, DOYLE FRAZIER, Columbus. Born Laurel, MS, Aug. 22, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned University Medical Center, Jackson, one year; internal medicine residency, same, 1975-77; elected by Prairie Medical Society.

TARVER, RUSSELL STOVALL, Greenville. Born Greenwood, MS, Sept. 29, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned University Medical Center, Jackson, one year; internal medicine, same, 1977-80; elected by Delta Medical Society.

VOLLER, ROBERT DALE, JR., Columbus. Born Springdale, OH, Dec. 11, 1948; M.D., University of Nebraska College of Medicine, Omaha, NE, 1975; interned Keesler AFB, Biloxi, MS, one year; pediatric residency, same, 1976-79 and Medical College of Georgia, Augusta, 1978-79; elected by Prairie Medical Society.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine[®]) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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complications can develop*.**

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for adjunctive therapy of duodenal ulcer*
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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addic-

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms; increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MSMA's Jail Health Project sponsored a recent workshop on providing mental health services to inmates. Participants included, from left: Dr. Faye Spruill of Jackson, State Medical Examiner and member, State Board of Corrections; Mike Haley of Linden, AL, psychologist on the staff of the West Alabama Mental Health Center and coordinator of criminal justice services in Marengo County, AL, course instructor; Carole Morgan of Boulder, CO, director of the Mental Health in Jails Project for Training Associates, Inc., instructor; Dr. Glen Anderson of Jackson, director of the Department of Mental Health; Ella Tardy of Jackson, project coordinator; and Dr. Virginia Tolbert of Parchman, chairman of the project's advisory committee.

Reproductive Endocrinology Course Scheduled in October

"Reproductive Endocrinology" is the topic of a postgraduate course scheduled for Oct. 18-19, at the Coliseum Ramada Inn in Jackson.

Held in conjunction with the 28th Annual Meeting of District VII of the American College of Obstetricians and Gynecologists, the course will deal with the subjects of ovulatory disorders, sexual differentiation, lactation, physiology of the menopause, estrogen and endometrial carcinoma, and the management of galactorrhea.

The faculty includes Drs. Paul C. MacDonald and Barry E. Schwarz of the University of Texas Health Science Center in Dallas and Dr. G. William Bates of the University Medical Center, Jackson.

The course is accorded 12 cognates and 12 hours in Category 1 of the Physician's Recognition Award of the AMA. The ACOG District Meeting is accorded 18 cognates and 18 hours, AMA.

The ACOG program features symposia on gynecologic pathology, obstetrical problems and obstetric-gynecologic infections, and a special address, "Epidemiology of Breast Disease."

Registration fee for non-Fellows is \$200. For more information about the postgraduate course or about the ACOG District Meeting, contact Dr. C. G. Sutherland, 918 North State St., Jackson, MS 39201 or Dr. George Ball, 1820 Hospital Dr., Jackson, MS 39204.

Dr. Ed Hill Named MAFP President

Dr. J. Edward Hill of Hollandale was installed as the 33rd president of the Mississippi Academy of Family Physicians during the Academy's recent annual meeting in Biloxi. Dr. Sam Nixon, president-elect of the American Academy of Family Physicians, conducted the installation ceremonies.

Elected to serve with Dr. Hill were: Dr. Ben Kitchens of Iuka, president-elect; Dr. Louis Rubenstein of Ocean Springs, vice president; Dr. Hardy Woodbridge of Jackson, secretary-treasurer; Dr. Joseph E. Johnston of Mt. Olive, delegate; and Dr. Eugene Wood of Jackson, alternate delegate.

Elected to the Board of Directors were Drs. James Waites of Laurel, Eugene Wood of Jackson, Walter Johnston of Vicksburg, Leonard Brandon of Starkville, and Malcolm Moore of Tupelo.

Dr. Joseph E. Johnston of Mt. Olive received the John B. Howell Memorial Award for outstanding service to family medicine in Mississippi, and Dr. Paul Eugene Sheffield of Jackson received the Outstanding Senior Award.

Governor Winter Proclaims Family Doctor Week



Dr. J. Edward Hill of Hollandale, 1980-81 president of the Mississippi Academy of Family Physicians, was present as Governor William F. Winter proclaimed the week of July 6-12 as Family Doctor Week in honor and recognition of family physicians in Mississippi.

PLACEMENT SERVICE

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OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

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PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PHYSICIANS

One of America's largest health care corporations is currently seeking both a full and part-time Physician for our Plasma Donor Center located in Mississippi. Responsibilities will include performing physicals in conjunction with donor screening and evaluation. The part-time position would provide support when regular staff physicians are on vacation.

Our requirements are flexible and we will consider licensed but non-practicing physicians as well as those desiring to work on a consulting basis.

We offer excellent working environment and a highly competitive salary. For further information, please send curriculum vitae to:

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17842 Irvine Blvd., Suite 118
Tustin, California 92680

Equal Opportunity Employer M/F

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

BOARD ELIGIBLE OB-GYN concluding 4-year Ob-Gyn residency July 1 seeking solo, association or partnership position in semi-rural area of Southeast. Contact: James D. Long, M.D., 131 Beverly Ave., Norfolk, VA 23505.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

FAMILY PHYSICIAN seeking a group practice opportunity in Mississippi. Graduate of Mississippi College and University of Mississippi School of Medicine, (1978). Presently serving residency at Roanoke Memorial Hospital. Contact Robert C. Lee, M.D. 2325 Avenham Ave., Apt. #6, Roanoke, VA 24014, or call 703/344-3506.

LOCUM TENENS work wanted — family and general practice, open availability. Contact T. C. Kolff, M.D., (801) 566-1666.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar De-Sai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

CLASSIFIED

PHYSICIANS WANTED. Pediatric and/or family practice physician wanted to help staff Hinds County Health Department Clinic. Ob-Gyn, pediatrician or family practitioners needed to staff health department clinics in areas outside Jackson area. Contact Dr. C. E. Fox, P. O. Box 1700, Jackson, MS 39205 or call (601) 354-6680.

OFFICE FOR LEASE (2,000 sq. ft., available July 1, 1981). Located in professional area of Tupelo, across street from 600-bed North Mississippi Medical Center. Family practitioners or other interested physicians, please contact Frank C. Baker, D.D.S., 810 Garfield Dr., Tupelo, MS 38801 or telephone 601/842-8035 (office) or 601/842-5224 (home).

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Index to Advertisers

Alpha Therapeutics	210
Boots Pharmaceuticals	6A, 6B, 6C, 6D
Burroughs Wellcome	10, 201
Canton Exchange Bank	191
Citizens Bank	3
Coca-Cola	10
Darkroom	207
Harreld Chevrolet	191
Janssen Pharmaceutica	16, 17
Eli Lilly and Company	8

Merck Sharp and Dohme	10B, 10C, 10D
Merrell National, Inc.	14, 14A, 208, 208A
Miss. Medical Fraternal and Educational Society	18
Mississippi Stationery	204
Parke, Davis	4
Premier Printing	3
Riverside Hospital	7
Roche Laboratories second, third, fourth covers, 3, 14B, 14C, 14D, 208B
South Central Bell	12
Southern Environmental Products	11
Wyeth Laboratories	18A, 18B
Thomas Yates and Co.	6

IN CONCLUSION

Since last year there has been an increase of 133 physicians in the state, resulting in a ratio of one primary care physician for every 1,838 people. A detailed report will appear in a special article in an upcoming issue of Journal MSMA...Mississippi's application for residual influenza funds has been approved, reversing a "lost cause" situation which resulted when Congress did not renew the influenza vaccine grant program and it was too late to seek state legislative support, reports Dr. Durward Blakey, director of the Bureau of Disease Control.

Workers have shown an increasing tendency to sue their own unions over a variety of matters, and the trend is spreading to health and safety issues, reports "Business Week." One reason is that worker expectations have been raised by union successes in negotiating a greater voice in health and safety rules. Lawsuits attempting to hold unions liable for job-related diseases, injuries and deaths have been the result. The cost - thousands of dollars in damages and legal fees - is forcing unions to seek changes in labor laws and contracts that lessen their liability.

Use of lithium in the successful treatment of manic-depression has not only rescued thousands of individuals from serious illness but also has saved some \$4 billion in treatment costs and gained production in the last ten years, reports Archives of General Psychiatry. Researchers from the National Institute of Mental Health and St. Elizabeth's Hospital in Washington, DC, estimate the total savings represents \$2.88 billion in actual treatment costs and \$1.28 billion in production gained from individuals who were able to return to work.

Laboratory medicine as now practiced in the U.S. is more advanced and of better quality than in any other nation in the world, says a new book from the AMA. Laboratory Tests in Medical Practice is the work of the Council on Scientific Affairs, in response to allegations of the federal government that lab tests in the U.S. had a high degree of error. An advisory panel of physicians prepared the volume, which touches on current uses of lab tests, errors to which they are subject, quality control they require, and clinical relevance of their increasing precision.

The Colorado surgical team that pioneered in liver transplantation reports a setback in the program that brought it almost to a halt for a time. Dr. Thomas E. Starzl reports in Archives of Surgery that of the last 23 cases of liver transplantation, only six individuals survived for as long as one year. Previously, the survival rate had been slowly climbing and had reached 50% in one group of 30 patients. Factors involved in the poor survival rate included faulty case selection, technical complications, use of damaged organs, and complications of suppressing rejection.

LIBRARY

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OF MEDICINE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the BactrimTM

3-system counterattack



Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens in the urethra.

Studies have shown that Bactrim acts against *bacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

N.Y. ACADEMY OF MED.
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NEW YORK N.Y.

11022

October 1980

BALCONY

Journal of the
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(ISSN 0026-6396)

Contents:

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Ectopic Thymus

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Republicans



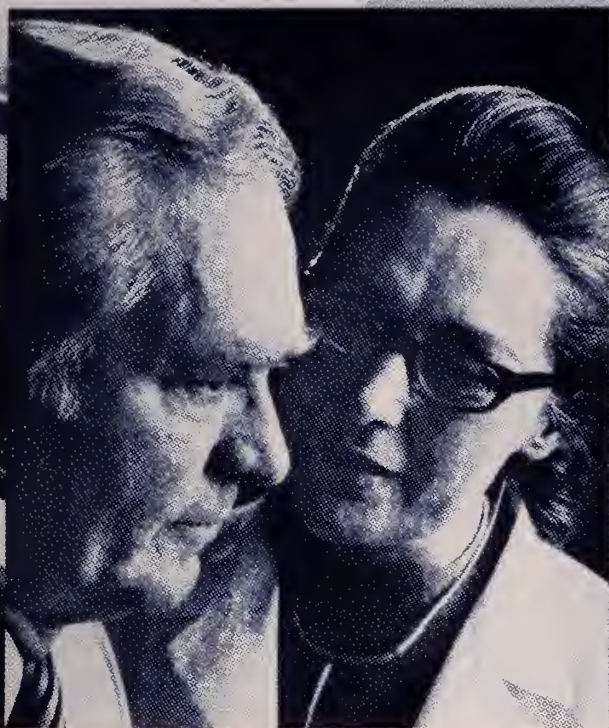
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proven antianxiety

Highly specific calming action
virtually free of unwanted
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clinical promise of Librium (chlordiazepoxide HCl).
And today this promise continues to be
fulfilled in a wide variety of patients
you see every day.

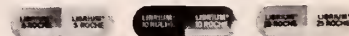
ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium®
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

***synonymous
with relief
of anxiety***

Please see next page for summary of product information.

Librium[®] 5mg, 10mg, 25mg capsules *chlordiazepoxide HCl/Roche*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss pregnancy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentia drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium[®] (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs[®] (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Products Inc.
Manati, Puerto Rico 00701

Vascular Anomalies of the Brain Will Be Seminar Topic

The University of Mississippi Medical Center will host a two-day seminar on "Vascular Anomalies of the Brain: Traditional and Modern Concepts" Nov. 14-15 at the Holiday Inn Downtown in Jackson.

The course will stress newer diagnostic and therapeutic techniques for cerebral arteriovenous fistulae and aneurysms. Practical application of balloon catheter techniques and the use of both solid and liquid emboli will be emphasized.

Sponsors are the UMC School of Medicine Departments of Neurosurgery, Neurology and Radiology and the UMC Division of Continuing Health Professional Education. Course coordinators are Dr. Armin Haerer, UMC professor of neurology; Dr. William Russell, UMC assistant professor of radiology and instructor in neurology; and Dr. Robert R. Smith, UMC professor of neurosurgery and department chairman.

Guest faculty include Dr. William Bank, department of radiology, Veterans Administration Medical Center, San Francisco; Dr. Gerard M. Debrun, professor of diagnostic radiology, and head of the neuroradiology section at the University of Western Ontario in London, Ontario, Canada; Dr. Alan S. Fleischer, associate professor of neurosurgery, Emory University School of Medicine, Atlanta; and Dr. W. Jost Michelsen, associate professor of neurosurgery at Columbia University, New York City.

Registration fee is \$175. The course carries 10.5 credit hours in Category I of the Physician's Recognition Award of the American Medical Association.

Partial support is from the Sloan Visiting Professor Fund in Radiology and the House Staff Continuing Medical Education Fund of the Medical Alumni Chapter of the University of Mississippi Alumni Association.

For registration information, contact Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

ACOG Schedules CME Course

"Reproductive Endocrinology," a postgraduate course schedule in conjunction with the 28th Annual Meeting of the American College of Obstetricians and Gynecologists, will be conducted Oct. 18-19 at the Coliseum Ramada Inn in Jackson. For more information, contact Dr. George Ball, 1820 Hospital Dr., Jackson, MS 39204.

JOURNAL of the **MISSISSIPPI** State Medical Association



October 1980, Volume XXI, Number 10

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CONTENTS

ORIGINAL PAPERS

- Reye's Syndrome **211** RONALD E. GRAY, M.D. and
NELL J. RYAN, M.D.
Jackson, MS
- Spontaneous Rupture **214** W. WILSON DEFORE, JR., M.D.
Of the Esophagus and RUSH E. NETTERVILLE, M.D.
Jackson, MS
- Radiologic Seminar **217** MARY ANN COWART, M.D.
CCVII: Ectopic Thymus Jackson, MS

SPECIAL ARTICLES

- Health Care Issues **220** Reprinted from the Platform
Of the Democratic Party
- Health Care Issues **221** Reprinted from the Platform
Of the Republican Party

EDITORIAL

- It's That Time Again! **225** GEORGE H. MARTIN, M.D.
Vicksburg, MS

THIS MONTH

- Auxiliary Page **223** 1980 Convention Report
- The President Speaking **224** What Choice?
- Medical Organization **225** MSMA-Robins Award
Nominations

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TWIN-K[®]

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For the Majority of Steroid-Responsive
Dermatoses* Seen in Family Practice

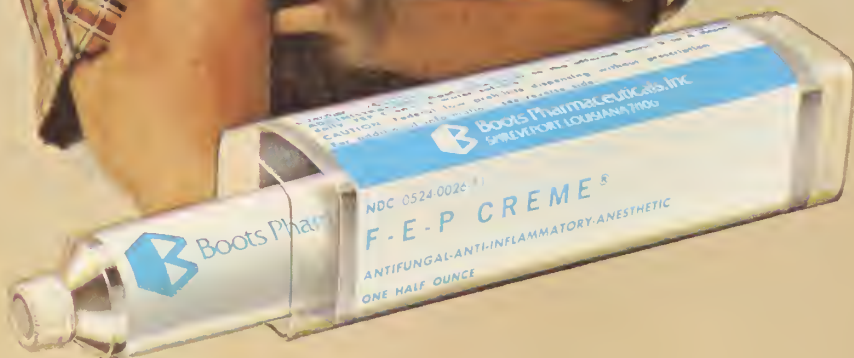
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(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.



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TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."¹

Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.



For the Geriatric Patient

SU-TON[®]

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylentetrazol.	30 mg
Niacin.	50 mg
Vitamin B-1.	10 mg
Vitamin B-2.	5 mg
Vitamin B-6.	1 mg
Vitamin B-12.	3 mcg
Choline.	100 mg
Inositol.	50 mg
Manganese (as Manganese Sulfate).	1 mg
Magnesium (as Magnesium Sulfate).	2 mg
Zinc (as Zinc Sulfate).	1 mg
Iron (as Ferric Pyrophosphate, Soluble).	22 mg
Alcohol.	18%

See prescribing information on last page of this advertisement.

Please send me patient starter samples of:

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☐ TWIN-K[®]

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F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.

2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice,

two to four times a day. This will supply 40 to 80 mEq of elemental potassium. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) or TWIN-K are to be avoided.

Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a prescription.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE: SU-TON contains pentylenetetrazol which may be helpful in the older patient as an anesthetic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS: Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSE AND ADMINISTRATION: One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-0015-16

CAUTION: Federal law prohibits dispensing without a prescription.

AP-001

5-80

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The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

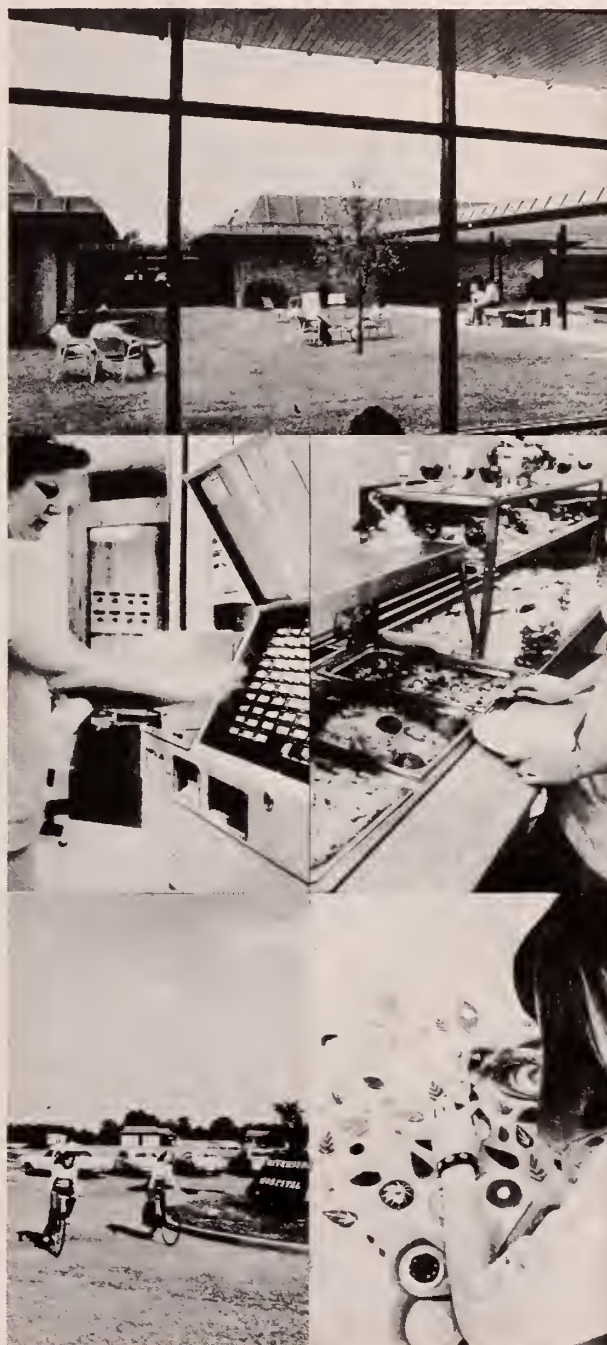
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modern anorectal comfort

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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PARKE-DAVIS
Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA

2/80

NEWSLETTER

October 1980

Dear Doctor:

A recognized expert on American health quackery sees a gloomy outlook in public opinion that foretells an increased turning to non-scientific medicine for the curing of illnesses. J. Harvey Young, professor of history at Emory University, says, "the climate is such that both friends and foes of unorthodoxy are predicting its triumph over orthodox medical science in the great contest for the allegiance of the public."

A shattered faith in universal progress and in the goodness of human nature, along with a disillusionment with science and the bureaucracy, has shaken people's faith, he said, pointing to the one billion dollars spent each year for unproven arthritis remedies. He said education and regulation can restrain quackery's toll in wasted resources.

According to medical society public relations specialists, the profession's major communications goals for the next few years should include restoring the image of the doctor, maintaining credibility, promoting healthy lifestyles, strengthening ties to the media, improving internal as well as external communications, and focusing on the need to adjust to changing priorities.

The tools economists employ to assess cost-benefit ratios are of limited value in health care, the Congressional Office of Technology Assessment (OTA) has conceded. The OTA report examining shortcomings and strengths of economic standards came as a relief to the health professions, which have feared that strictly economic judgments could discourage valuable technological methods, such as CT scanners.

Congress is completing action on a major expansion of the Community Mental Health Center Program. The House approved a four-year extension authorizing \$78 million next year, climbing to \$200 million by 1984. The bill involves the states in the planning and provision of services, and calls for establishing special services for the chronically mentally ill and for disturbed children.

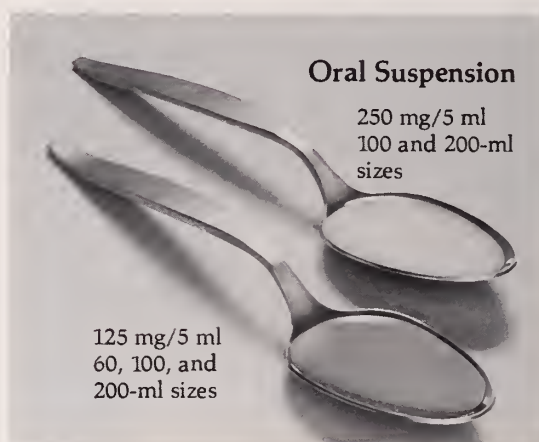
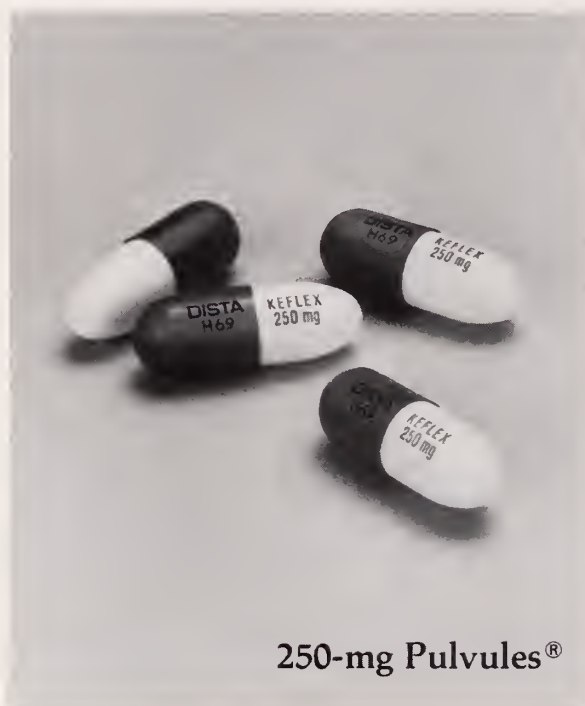
Dr. Michael Halberstam, internist, columnist and author, says Americans have developed a phobia about taking tranquilizers. Conceding that many doctors do not agree, he claims the media have pictured the country as a nation of addicts and have created the idea that the use of tranquilizers is something to be ashamed of, producing unnecessary guilt feelings about "dependence."

Sincerely,



Patsy Silver
Managing Editor

easy to take



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to the profession on request.



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WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] (meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlori-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and re-institution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa 19101



FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in *one* tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as abuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group. **PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, (a) undue coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory in addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus*, volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes

may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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A thesis summary of 75 to 100 words must accompany each manuscript.

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In addition, in view of *The Copyright Revision Act of 1976*, effective Jan. 1, 1978, transmittal letters to the editor should contain the following language: "In consideration of the Mississippi State Medical Association's taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the MSMA in the event that such work is published by the MSMA." We regret that transmittal letters not containing the foregoing language signed by *all* authors of the submission will necessitate delay in review of the manuscript. — *The Editors.*

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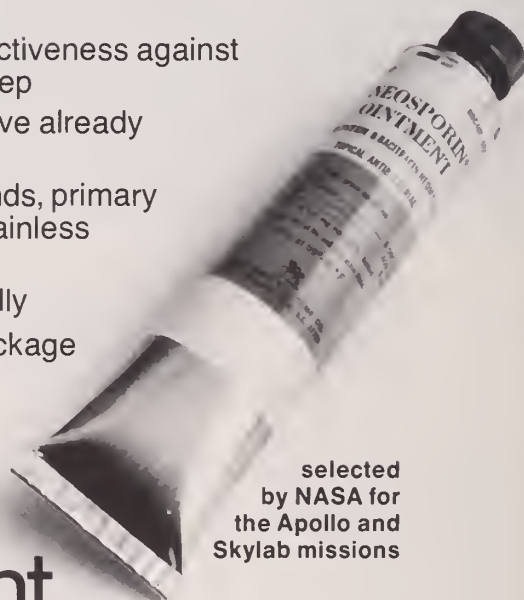
Polymyxin B

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1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML



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DATELINE

Rocky Mountain Spotted Fever Alert Jackson, MS - The possibility of Rocky Mountain Spotted Fever should be considered when any otherwise unexplained febrile illness is observed at this season of the year, reminds the state's Bureau of Disease Control. Dr. Durward Blakey, director, urges physicians to report cases under their care to the local health department. Specific antibiotic therapy (tetracycline or chloramphenicol) is essential to reduce to a rare event the possible 20% mortality, he reminds.

Disabled Physicians Program Expands Jackson, MS - MSMA's Disabled Physician Program, directed by Dr. D. P. Smith, has moved to new offices at Suite 406, 440 E. Woodrow Wilson, Jackson, MS 39216 (telephone 366-7483 or 800-682-6415). The Program recently expanded with the opening of the Caduceus Outpatient Addiction Center (COPAC). The learning center's program features a combination of group therapy and individual education for the chemically addicted. John Bedwell is COPAC director.

Five Jails Join MSMA Project Jackson, MS - Five additional county jails have applied for technical assistance through MSMA's Jail Health Care Project. The jails in Claiborne, Lauderdale, Leflore, Madison, and Simpson counties join 13 other Mississippi jails already enrolled in the program to improve their health care systems. The Jail Project Advisory Committee, chaired by Dr. Virginia S. Tolbert of Parchman, approved the addition of these jails at the committee's October 4 meeting.

SLE Cases Are Confirmed Jackson, MS - The Bureau of Disease Control has received serologic confirmation of two cases of St. Louis Encephalitis in Mississippi. The patients, a 13-year-old white male and a 49-year-old white female, are recovering from illnesses which began early in August. Surveillance and mosquito control have been intensified in the affected areas-Harrison and Jackson counties. Physicians are urged to draw both acute and convalescent sera for SLE.

CME Courses Total 8,938 Chicago, IL - Some 8,938 CME courses for physicians will be offered in the U.S. in the year beginning Sept. 1, according to a listing published recently in JAMA. (Total listing of courses in 1961-62 was 1,105.) Internal medicine, with 1,646 courses, is the most popular field for CME; psychiatry is second with 1,282 courses. In the past year, the AMA has awarded 34,851 Physicians Recognition Awards to physicians completing a minimum of 150 hours of CME.

Dr. Debra Rodgers Receives Third Annual Jaquith Award



Dr. Debra Savage Rodgers of Jackson (second from left) received the third annual William Jaquith Award presented by the Department of Psychiatry and Human Behavior at the University of Mississippi Medical Center. Sandoz Pharmaceuticals sponsors the award. The award, named in honor of the former director of the State Hospital at Whitfield, goes to the UMC psychiatry resident who shows the greatest promise during postgraduate training. With Dr. Rodgers are (from left) Jim McLoughlin, Sandoz medical sciences liaison; Dr. Jan Duker, director of the Mississippi Department of Mental Health; and Dr. Edgar Draper, UMC professor of psychiatry and human behavior and department chairman.

UMC Schedules Third Annual Course on Strabismus

The University of Mississippi Medical Center will host its third annual course on strabismus Dec. 12-13 in Jackson.

Dr. David L. Guyton, assistant professor of ophthalmology at Johns Hopkins University School of Medicine in Baltimore, will present the lecture. Dr. Guyton has been a consultant on ophthalmic instrumentation to the American Academy of Ophthalmology. Author of papers in more than 20 scientific journals, Dr. Guyton's basic research interest is the design and construction of instruments for automated refraction of the eye.

Course sponsors are the University of Mississippi School of Medicine Department of Surgery Division of Ophthalmology, the Division of Continuing Health Professional Education and the Jackson, MS, Central Lions Club.

There is no registration fee. For information, write Dr. Raul E. Valenzuela, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

Tenuate®

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., D. Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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**Overweight may not always be simple...
complications can develop*.**

Complicated or not...

Tenuate[®] Dospan[®] (IV) **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page.

α

Alpha Stimulation

Central Control of
Blood Pressure*



*The Family of Man® by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres

The Alpha Advantage:

It's for all kinds of hypertensives

- Unlike beta blockers, Catapres® has no contraindications.
- Catapres can be useful even in these patients with:

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido:
2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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0.3 mg tablets**

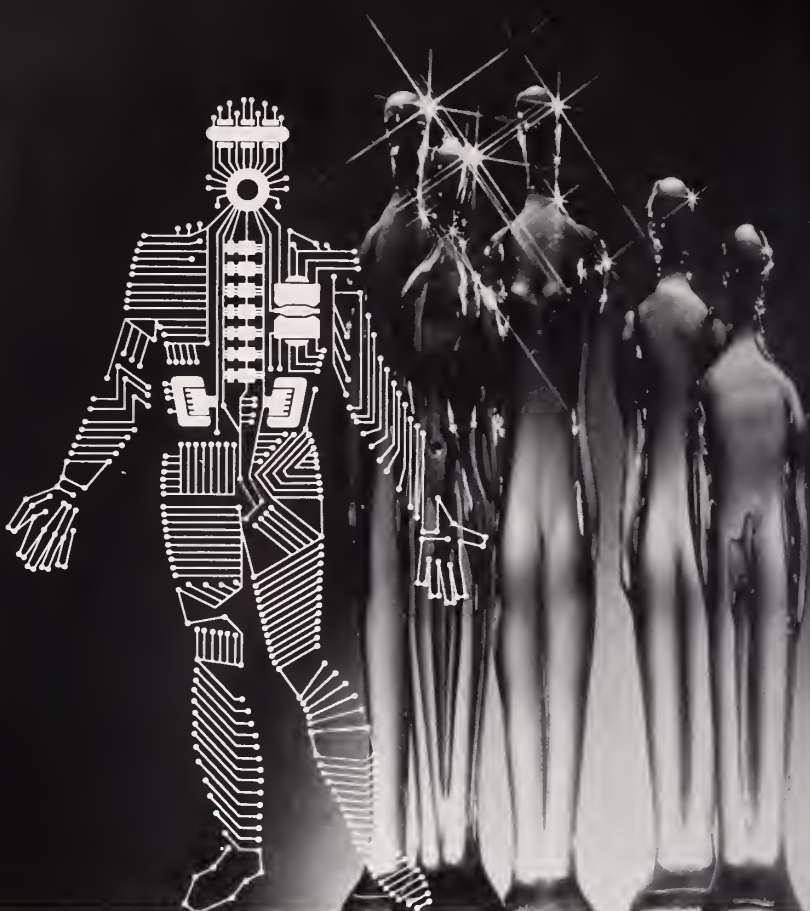
Tablets of 0.1, 0.2, 0.3 mg
Catapres®
(clonidine HCl)
Hypertension



α

The Alpha Advantage: It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg
Catapres[®]
(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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POSTGRADUATE CALENDAR

Oct. 20-24, 1980 and Jan. 19-23, 1981

THE PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine and the Medical Center Division of Continuing Health Professional Education.

Coordinator: Thomas M. Blake, M.D., professor of medicine, University of Mississippi School of Medicine.

This program will discuss mechanism, structure and function of electrocardiography for physicians who use electrocardiography in their everyday practice. New methods will be discussed with emphasis on the computer. Fee: \$160. Credit: 40 contact hours (4 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

Nov. 5-8, 1980

FAMILY PRACTICE UPDATE
Jackson Hilton, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine, the Medical Center Division of Continuing Health Professional Education and the Mississippi Academy of Family Physicians.

Coordinator: Robert C. Forbes, M.D., assistant professor of family medicine, and Robert F. Willis, M.D., assistant professor of family medicine, University of Mississippi School of Medicine.

This annual family medicine continuing medical education program is designed to bring timely and relevant information to the primary care physician. The seminar will include lecture and panel discussions. Beginning on Wednesday videotape presentations may be viewed on your hotel room television each evening from 10:30 to 12:00, and each morning from 6:00 to 7:30. Fee: \$115. Credit: 20.5 contact hours (2.05 CEU) Category I of the Physician's Recognition Award, AMA; AAFP credit applied for.

Nov. 14-15, 1980

VASCULAR ANOMALIES OF THE BRAIN: TRADITIONAL AND MODERN CONCEPTS
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Departments of Neurosurgery, Neurology and Radiology and the Medical Center Division of Continuing Health Professional Education.

Coordinators: Armin Haerer, M.D., professor of neurology; William Russell, M.D., assistant professor of radiology and instructor in neurology; and Robert R. Smith, M.D., professor of neurosurgery and department chairman, University of Mississippi School of Medicine.

This course will stress newer diagnostic and therapeutic techniques for cerebral arteriovenous fistulae and aneurysms. Practical application of balloon catheter techniques and use of both solid and liquid emboli will be emphasized. Fee: \$175. Credit: 10.5 contact hours (1.05 CEU) Category I of the physician's recognition Award, AMA.

Dec. 4-5, 1980

SECOND ANNUAL MISSISSIPPI PERINATAL POSTGRADUATE COURSE
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine; the Department of Pediatrics Division of Newborn Medicine; the University of Mississippi School of Nursing; and the Medical Center Division of Continuing Health Professional Education.

Coordinators: John C. Morrison, M.D., professor of obstetrics and gynecology and director of the division of maternal-fetal medicine; and Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine, University of Mississippi School of Medicine.

Advances in the field of perinatal health care will be presented in this two-day program. Sessions will include effects of obstetric analgesia and anesthesia on the newborn, asphyxia neonatorum, nutrition counseling for pregnant women, the use of ultrasound in obstetrics and prenatal diagnosis of congenital malformation. Fee: \$150 for physicians. Credit: 12.5 contact hours (1.25 CEU) Category I of the Physician's Recognition Award, AMA; AAFP Credit applied for.

For information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone (601) 987-4914.

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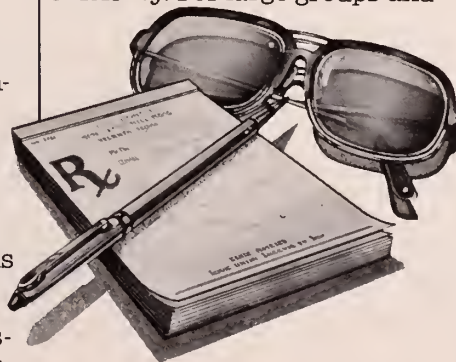
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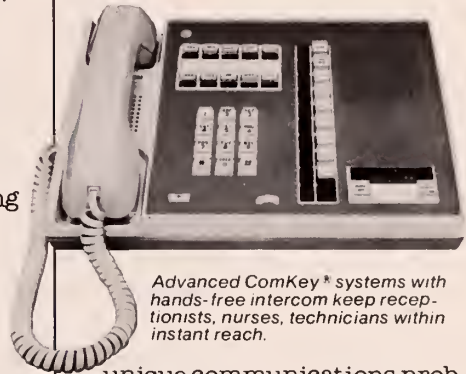
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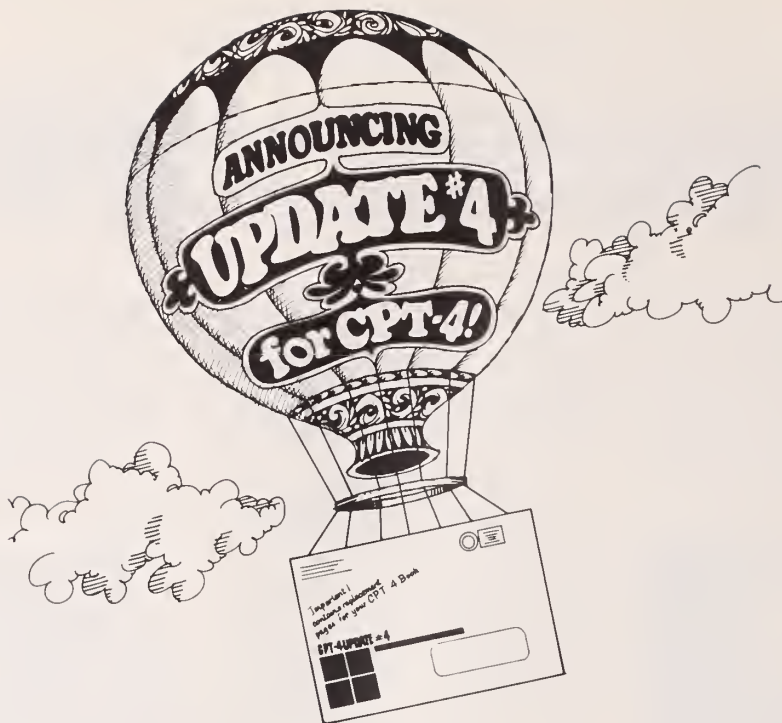
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ORIGINAL PAPERS

Reye's Syndrome

RONALD E. GRAY, M.D. and NELL J. RYAN, M.D.

Jackson, Mississippi

REYE'S SYNDROME, while remaining an enigma to the medical profession, recently has been the object of considerable attention by the lay press. A case of Reye's syndrome seen recently at the University Hospital illustrates several features of the disease and its treatment that are of interest to practitioners.

This 12-year-old white girl was in good health until six days prior to admission when she developed fever, a sore throat and mild abdominal pain. She was seen by her physician and began taking an antibiotic. The child also received aspirin, 10 grains every three hours. Her symptoms, however, persisted, and one day prior to admission she began vomiting and became lethargic. When seen in the local emergency room she was combative and disoriented. She was then transferred to a pediatrician. The child remained combative and disoriented and was considered to have either an encephalitis or a drug intoxication. Toxicology screen (exclusive of salicylate) was negative on two occasions. Pertinent laboratory studies revealed elevated liver function studies, elevated muscle enzymes, and an elevated white cell count. Spinal fluid examination was normal.

The child's condition continued to deteriorate and by the next morning she was comatose. She was then referred to the University Hospital. On arrival at the Children's Hospital the child was comatose and decerebrate. Fundoscopic examination revealed venous engorgement and retinal edema but no papilledema. The liver and muscle enzymes were again elevated and the plasma ammonia concentration was 432 micrograms/100 ml (normal 30-50). The white

cell count was 26,000 with a marked shift to the left. The electroencephalogram was grossly normal. Serum salicylate level was 26.9 mg/100 ml (therapeutic range 25-30). The clinical diagnosis was Reye's syndrome.

Reye's syndrome usually follows a viral illness, but its precise etiology remains obscure. The interaction of viruses with either inborn metabolic abnormalities or exogenous toxins (including drugs) has been implicated. The underlying pathogenetic mechanism seems to be disruption of mitochondrial oxidative function which results in widespread derangement of metabolism. This is manifested anatomically by cerebral edema and fatty degeneration in the visceral organs. The authors present a case report.

Shortly after admission the patient developed seizure activity and was given anticonvulsants. An intracranial pressure monitor was inserted. Therapeutic measures were instituted to control the cerebral edema and to maintain the blood glucose. The child's course was rapidly downhill and, terminally, she developed hypotension with poor peripheral perfusion which was refractory to all therapeutic measures. She expired on the second hospital day.

At postmortem examination, the brain was severely edematous, and there were moderately advanced cerebellar and temporal lobe pressure markings (see Figure 1). The liver was enlarged and, along with the kidneys and heart, had a striking pale yellow discoloration. The spleen was enlarged, but was not other-

From the Department of Pathology, University Medical Center (Dr. Gray) and the Departments of Pediatrics and Neurology, University of Mississippi School of Medicine (Dr. Ryan), Jackson, MS.

REYE'S SYNDROME / Gray and Ryan

wise abnormal. There were patchy areas of consolidation scattered throughout both lungs, suggesting bronchopneumonia.

Microscopic study revealed fatty degeneration of the liver, kidney, and myocardium (see Figure 2). Histologic sections of the brain showed only severe edema and evidence of neuronal hypoxia. There was no inflammation.

Electron microscopic study of the liver revealed swelling of mitochondria, with disruption of their internal structure.



Figure 1. Gross photograph showing moderately advanced cerebellar pressure markings. The cerebellar tonsils are tightly applied about the brainstem.

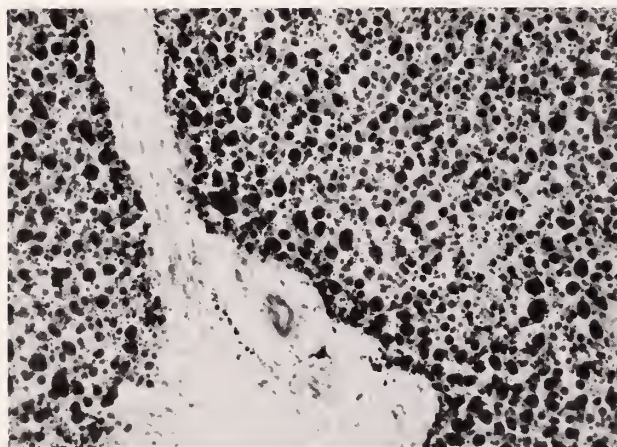


Figure 2. Photomicrograph of liver showing intracellular fat vacuoles of varying sizes. (Oil red O stain, original magnification 400 \times .)

There was a severe, necrotizing bronchopneumonia affecting both lungs. Some bronchioles contained foreign matter which resembled meat fibers. Therefore, we consider that the bronchopneumonia occurred as a result of aspiration, and represents a complication of the patient's immobilization and altered mental state.

Discussion

A clinical syndrome associated with encephalopathy and fatty degeneration of visceral organs was recognized by the Australian pathologist R. D. K. Reye and his co-workers in 1963.¹ The disease usually affects children, but cases occurring in adults have been reported.² Although the cause remains obscure, it is known that the disorder is usually preceded by infection with any of a wide variety of common viruses³ and is recognized clinically by disturbances of mentation, vomiting, seizures, hypoglycemia, and evidence of abnormal liver function. The mortality rate is high (20% to 40%).³

The pathological findings are characteristically nonspecific, consisting of edema and hypoxic changes in the brain with fatty degeneration of the liver, kidneys, heart, and sometimes other visceral organs.¹ Inflammation is conspicuously absent.³ Electron microscopy has shown swelling of hepatic and neuronal mitochondria, with disruption of their internal structure.^{3, 4} These changes have been observed to regress with clinical improvement.⁴

Published evidence suggests that there is a Reye's syndrome "Serum Factor" (separate from ammonia and free fatty acids) that is toxic to mitochondria, and that the clinical and anatomic features of the syndrome are due to disrupted mitochondrial oxidative function with resulting impairment of energy-requiring reactions throughout the body.^{4, 5}

That some children should develop Reye's syndrome following a viral illness, and the great majority not, has of course provoked considerable interest and investigation. It has been proposed that Reye's syndrome victims are genetically predisposed and metabolically unique, but evidence in support of this seems nonspecific.^{6, 7} That exogenous toxins (acting alone or in synergy with virus infections) may produce Reye's syndrome seems likely in view of the published evidence.^{3, 8, 9}

An important factor in the development of some cases of Reye's syndrome may involve the drugs (including aspirin, acetaminophen, antiemetics, and antihistamines) commonly administered to children with viral illness. Many such drugs, in sufficient quantities, are known to be directly toxic to

mitochondria or to have other hepatotoxic effects. The clinical course of salicylate intoxication is very similar to Reye's syndrome,¹⁰ and even in therapeutic doses, acetaminophen may be hepatotoxic in patients with a concurrent viral infection of the liver.^{11, 12}

This concern over the possible causal relationship of drugs to Reye's syndrome has prompted the Food and Drug Administration's Neurologic Drugs Advisory Committee to advise against the use of antiemetics, aspirin and acetaminophen in children for minor indications, and, specifically to avoid the use of such drugs in those children whose symptoms suggest Reye's syndrome.¹³

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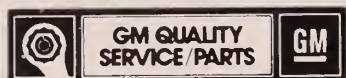
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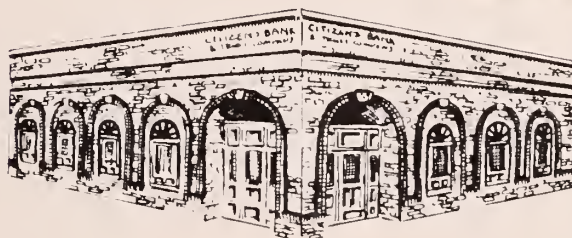
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Spontaneous Rupture of the Esophagus

W. WILSON DEFORE, JR., M.D. and RUSH E. NETTERVILLE, M.D.

Jackson, Mississippi

SPONTANEOUS RUPTURE of the esophagus, initially described by Boerhaave in 1724, represents a potentially lethal gastrointestinal tract emergency. Without prompt diagnosis aided by chest films and esophagograms and emergent surgical intervention, the mortality rates range from 60% to 100%. Surgical treatment includes thoracotomy with debridement and closure of the perforation and drainage of the pleural space.

Postoperatively, nutritional and ventilatory support, as well as antibiotic therapy, are utilized.

This review presents a case report and emphasizes the clinical features and treatment of this challenging surgical problem.

Case Report

A 63-year-old black female was seen in the emergency room of her local hospital in September 1979, following several episodes of violent vomiting and a five-day history of anorexia with upper abdominal discomfort. The episodes of vomiting were followed by dyspnea, upper abdominal and back pain, and diaphoresis. Medical history revealed that the patient had a gastric ulcer diagnosed in July 1977, and also had arteriosclerotic heart disease.

Initial examination revealed an anxious patient with a blood pressure of 90/70, a tachycardia of 115 per minute, and cool, clammy skin. The patient appeared acutely ill. Examination of the chest revealed decreased breath sounds on the left side, epigastric tenderness, and subcutaneous emphysema over the chest wall.

Laboratory data showed a hemoglobin of 11 gm, with white blood cell count of 9,100. Serum amylase values were within normal limits. An electrocardiogram showed no evidence of myocardial ischemia. The initial chest x-ray revealed a left hydropneumothorax to be present, and a tube thoracostomy was performed with drainage of 1300 ml of thin, brownish fluid showing *E. coli* on gram stain. A perforation of the esophagus was suspected, and a barium swallow revealed extravasation of the media from

the distal esophagus to the left posterolateral mediastinum.

Antibiotic therapy was begun and a left thoracotomy with debridement and closure of a distal esophageal perforation was performed. At surgery, there was residual fluid present in the left pleural

Spontaneous rupture of the esophagus represents a potentially lethal gastrointestinal tract emergency. Without prompt diagnosis and surgical intervention, the mortality rates are high. The authors present a case report and emphasize the clinical features and treatment of this challenging surgical problem.

space, with a marked mediastinal inflammatory reaction. Following repair, the pleural space and mediastinum were irrigated with copious amounts of saline and drained with a large-bore chest tube. Following the thoracotomy, a gastrostomy was performed. Postoperatively the patient continued to receive therapeutic doses of a broad-spectrum antibiotic and ventilatory support.

Discussion

Spontaneous rupture of the esophagus was first reported in 1724 by Herman Boerhaave, a Dutch physician, after his patient, Baron von Wassanaer, expired after an episode of self-induced vomiting. The patient had experienced violent vomiting, chest discomfort and shortness of breath, and at postmortem examination was found to have a tear in the distal esophagus.¹ In 1941, Frink² reported the first successful surgical case.

The condition is relatively uncommon and the majority of cases have been reported in recent years as physicians have become more aware of this problem.³ Untreated, spontaneous rupture of the esophagus demonstrates essentially a 100% mortality rate.⁴ In most series, males are involved in an average ratio of 3:1.

Dr. Defore and Dr. Netterville are practicing surgeons in Jackson, MS.

It appears that the precipitating factor is most often related to episodes of violent retching, but other causes including straining, parturition, coughing, blunt trauma and drug abuse have been implicated. Presumably the esophagus undergoes a rapid increase in intraluminal pressure with distention and consequent rupture. Abbott⁵ utilized the term "atraumatic panmural rupture of the esophagus," indicating that the condition is never actually "spontaneous" but is indeed secondary to some initiating factor. Most studies indicate that the rapid increase in intraluminal esophageal pressure leads to the disruption and not the actual pressure.

A review of the pathophysiology reveals most lesions to be in the left posterolateral aspect of the distal esophagus, a few centimeters above the diaphragm. This is due to a number of anatomic features of this area of the distal esophagus which lead to this predilection for weakness, including a thin covering of musculature, a lack of serosa, and the entrance of blood vessels and nerves in this area. Concurrent bleeding is rare and a shock-like state usually ensues quickly due to the mediastinitis caused by corrosive gastrointestinal contents and bacteria.

The most frequent clinical feature is chest and upper abdominal pain following episodes of forceful emesis. In addition, there is often dyspnea secondary to the respiratory compromise of the accompanying hydropneumothorax. There is occasionally an associated episode of hematemesis. The patient typically appears apprehensive and somewhat cyanotic with cool, clammy skin and is tachycardic with an impending shock-like state. Physical examination reveals a pronounced rigidity of the upper abdomen with decreased bowel sounds, often leading to an erroneous diagnosis of a perforated duodenal ulcer. As time progresses, the chest signs predominate with cyanosis, subcutaneous emphysema, hyperresonance and decreased breath sounds, and rales over the affected hemothorax become manifest.

Differential diagnosis should include the possibility of a perforated duodenal ulcer, acute myocardial infarction, pulmonary embolism, dissecting thoracic aneurysm, acute pancreatitis, and abdominal vascular accidents. These conditions often can be discerned with the use of chest and abdominal films, electrocardiograms, and serum chemical and amylase values.

Diagnostic studies usually demonstrate a leucocytosis with a "shift to the left" on differential count and the presence of hemoconcentration. The chest x-ray is the most valuable initial diagnostic study and typically may show a left hydropneumothorax,

tracheal and mediastinal deviation, basilar infiltrates, mediastinal air and subcutaneous emphysema in the chest wall soft tissues. An esophagogram with barium or water soluble media will show the site of perforation in approximately 75% of cases; however, the lack of extravasation does not exclude a perforation. In this highly suspect group of patients, endoscopy may be of benefit although this is usually risky in a seriously ill patient.

The majority of physicians agree that prompt operative intervention is the procedure of choice following initial diagnosis after the patient is rapidly resuscitated with volume replacement and is started on antibiotic therapy.

The most common surgical approach is through a left thoracotomy in the sixth or seventh intercostal space. The mediastinal pleura overlying the esophagus is marked by an intense inflammatory reaction and is opened in this area allowing approach and mobilization of the involved esophagus. Typical operative findings usually reveal a linear tear in the longitudinal axis of the distal esophagus on the posterolateral aspect. Once the perforation is identified, it is debrided and repaired with a two-layer closure, followed by irrigation and drainage of the pleural space. Reinforced buttresses of pleura, lung, pericardium and diaphragm, or fundoplication techniques are advocated prophylactically by some surgeons^{6, 7, 8, 9} to avoid breakdown and leakage of the esophageal repair due to a compromised pathologic condition. A variety of other techniques of esophageal exclusion,¹⁰ diversion and tube drainage⁵ have also been reported but not generally adapted for the standard repair. A gastrostomy may be performed to allow for effective decompression and early feeding. In addition, nutrition of the debilitated patient may be maintained with total parenteral nutrition, an especially useful adjunct in the patient with an esophageal fistula, a not infrequent complication in the alcoholic or poorly nourished patient. Postoperatively, fluid replacement and electrolyte balance, antibiotic therapy, and parenteral intravenous nutrition may be utilized along with respiratory support as indicated.

Conclusion

Spontaneous rupture of the esophagus is an emergent surgical condition associated with a prohibitive mortality if untreated. Prompt diagnosis and treatment of this condition is a continuing surgical challenge. Without treatment, it is associated with a fatal prognosis due to combined factors of respiratory distress, shock, fluid and electrolyte losses, and overwhelming sepsis. With surgical intervention,

operative mortality ranges from 10% to 40%. The time interval between the onset of perforation and initiation of surgical treatment directly influences the prognosis. Surgical treatment includes thoracotomy with debridement and closure of the perforation, and drainage of the pleural space. Postoperatively the parameters of nutritional and ventilatory support, as well as infection control, should be monitored closely. The condition demands an awareness and early recognition with prompt and aggressive surgical therapy for effective treatment. ★★★

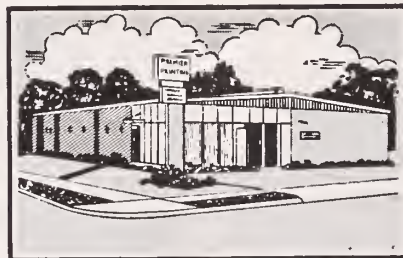
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Radiologic Seminar CCVII: Ectopic Thymus

MARY ANN COWART, M.D.
Jackson, Mississippi

THERE ARE CONSIDERABLE normal variations in the size and configuration of the thymus gland. In recent years, it has been accepted that normal thymic tissue cannot cause respiratory difficulty. For this reason, thymectomies and ablative thymic irradiation for hypertrophied thymus have been discontinued.¹

However, the normal thymus may assume an anomalous position and thus represent a diagnostic problem. A case of ectopic thymus in the posterior mediastinum is presented to demonstrate the need to include ectopic thymus in the differential diagnosis of a posterior mediastinal mass in children.²

Case Report

A 4-month-old male was admitted because of an abnormal chest x-ray obtained during evaluation for possible sepsis. The infant was asymptomatic until about two weeks prior to admission when he developed cold symptoms. Initially, he was treated with oral antibiotics. However, when he developed coarse breath sounds and dyspnea, he was referred to University Medical Center for further evaluation. On physical examination, the infant was found to have loud upper airway sounds with bilateral rales. A chest film demonstrated a right upper posterior mediastinal mass (see Figures 1A and 1B). During the initial hospitalization, the infant was treated for viral pneumonitis with resolution of his symptoms. At this time, the mass was believed to represent probable thymic tissue. The patient was followed as an outpatient for two months with no change in the appearance of the mass. Then, he underwent an exploratory thoracotomy to exclude the possibility of a neurogenic tumor. At surgery, a mass was found arising from the middle and anterior mediastinum. The mass extended into the posterior mediastinum enveloping the esophagus as well as the nerves and vessels in this area. A frozen section demonstrated normal thymus without evidence of tumor. Surgery

was terminated without further resection. Permanent sections confirmed the diagnosis of normal thymic tissue. The child did well postoperatively.

Discussion

During the sixth week of embryonic life, the thymus originates in the neck as paired outgrowths of



Figure 1A

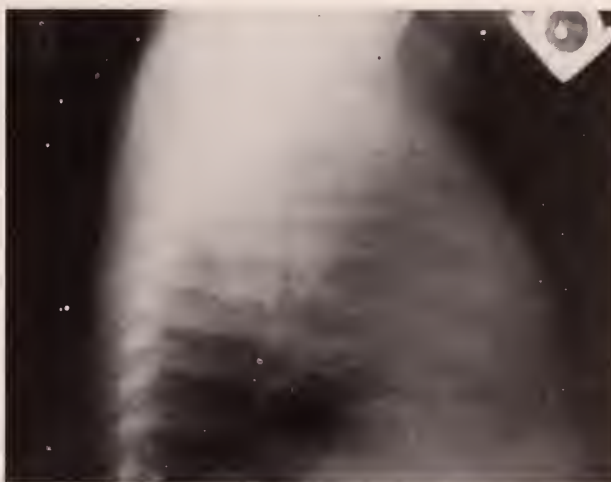


Figure 1B

Frontal (A) and lateral (B) radiographs. Mass density in posterior segment of right upper lobe.

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From the Department of Radiology, University Medical Center,
Jackson, MS.

ECTOPIC THYMUS / Cowart

the third pharyngeal pouches. As the tissue grows, it attaches to the pericardium and descends into the thorax. Usually, the thymic tissue is located in the anterior mediastinum and envelopes the pericardium and the great vessels at the base of the heart.¹

Ectopic cervical thymus is a well-known entity and probably results from growth of undescended remnants of thymic tissue. Ectopic thymus has also been reported in such bizarre locations as the angle of the mandible, pharynx and the cavum tympani.^{2, 3}

A few cases of posterior mediastinal accessory thymus have been described in the literature. The etiology of this entity remains obscure. In all cases reviewed, the ectopic thymic tissue was found in the right posterior mediastinum. Usually the patients were asymptomatic, but in one case there was com-

pression of the right mainstem bronchus with secondary obstructive emphysema. Most of the patients were noted to have normal thymus in the usual position, as in this patient.^{1, 2}

Unfortunately, thoracic CT scans were not obtained in any of the cases reviewed. Hopefully, CT will demonstrate the extension of the normal thymus into this ectopic site and eliminate exploratory surgery. In any event, ectopic thymus should be included in the differential diagnosis of childhood posterior mediastinal masses. ★★★

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The United States spent over \$200 billion for health care in 1979. Despite these high expenditures and although we possess some of the finest hospitals and health professionals in the world, millions of Americans have little or no access to health care services. Incredibly, costs are predicted to soar to \$400 billion by 1984, without improvement in either access to care or coverage of costs. Health care costs already consume ten cents of every dollar spent for goods and services.

The answer to runaway medical costs is not, as Republicans propose, to pour money into a wasteful and inefficient system. The answer is not to cut back on benefits for the elderly and eligibility for the poor. The answer is to enact a comprehensive, universal national health insurance plan.

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 - Reform of the health care system, including encouragement of health maintenance organizations and other alternative delivery systems;
 - Building on the private health care delivery sector and preservation of the physician-patient relationship;

- Provision for maximum individual choice of physician, other provider, and insurer;
- Maintenance of the private insurance industry with appropriate public regulation;
- Significant administrative and organizational roles for state and local government in setting policy and in resource planning;
- Redistribution of services to ensure access to health care in underserved areas;
- Improvement of non-institutional health services so elderly, disabled, and other patients may remain in their homes and out of institutions; and

"The answer to runaway medical costs is not, as Republicans propose, to pour money into a wasteful and inefficient system . . . the answer is to enact a comprehensive, universal national health insurance plan."

Child Health Assurance Program. We must continue to emphasize preventive health care for all citizens. As part of this commitment, we call for the enactment of legislation during the 96th Congress to expand the current Medicaid program and make an additional five million low-income children eligible for Medicaid benefits and an additional 200,000 low-income pregnant women eligible for prenatal and postnatal care.

Mental Health Systems Act. We must enact legislation to help the mentally ill, based on the recommendations of the President's Commission on Mental Health. The legislation should focus on deinstitutionalization of the chronically mentally ill, increased program flexibility at the local level, prevention, and the development of community-based mental health services. It is imperative that there be ongoing federal funding for the community-based mental health centers established under the 1963 Mental Health Act and that sufficient federal funding be provided for adequate staffing. We also endorse increased federal funding for ongoing training of mental health personnel in public facilities.

In the 1980s we must move beyond these existing health care initiatives and tackle other problems as well.

(continued on page 222)

Reprinted from the 1980 Platform of the Democratic Party.

Health Care Issues: The Republican Party Speaks

OUR COUNTRY'S UNEQUALLED SYSTEM of medical care, bringing greater benefits to more people than anywhere else on earth, is a splendid example of how Americans have taken care of their own needs with private institutions.

Significant as these achievements are, we must not be complacent. Health care costs continue to rise, farther and faster than they should, and threaten to spiral beyond the reach of many families. The causes are Washington's inflationary spending and excessive and expensive regulations.

Republicans unequivocally oppose socialized medicine, in whatever guise it is presented by the Democratic Party. We reject the creation of a national health service and all proposals for compulsory national health insurance. That would be the end of quality health care for all but the very rich.

Our country has made spectacular gains in health care in recent decades. Most families are now covered by private insurance, Medicare, or in the case of the poor, the entirely free services under Medicaid.

Republicans recognize that many health care problems can be solved if government will work closely with the private sector to find remedies that will enhance our current system of excellent care. We applaud, as an example, the voluntary effort which has been undertaken by our nation's hospitals to control costs. The results have been encouraging. More remains to be done.

What ails American medicine is government meddling and the strait-jacket of federal programs. The prescription for good health care is deregulation and an emphasis upon consumer rights and patient choice.

As consumers of health care, individual Americans and their families should be able to make their own choices about health care protection. We propose to assist them in so doing through tax and financial incentives. These could enable them to choose their own health coverage, including protection from the catastrophic costs of major long-term illness, without compulsory regimentation.

Americans should be protected against financial disaster brought on by medical expense. We recog-

nize both the need to provide assistance in many cases and the responsibility of citizens to provide for their own needs. Using tax incentives and by reforming federal medical assistance programs, government and the private sector can jointly develop compassionate and innovative means to provide financial relief when it is most needed.

"Republicans unequivocally oppose socialized medicine, in whatever guise it is presented by the Democratic Party. We reject the creation of a national health service and all proposals for compulsory national health insurance."

We endorse alternatives to institutional care. Not only is it costly but it also separates individuals from the supportive environment of family and friends. This is especially important for the elderly and those requiring long-term care. We advocate the reform of Medicare to encourage home-based care whenever feasible. In addition, we encourage the development of innovative alternate health care delivery systems and other out-patient services at the local level.

We must maintain our commitment to the aged and to the poor by providing quality care through Medicare and Medicaid. These programs need the careful, detailed reevaluation they have never received from the Democrats, who have characteristically neglected their financial stability. We believe that the needs of those who depend upon these programs, particularly the elderly, can be better served, especially when a Republican Administration cracks down on fraud and abuse so that program monies can be directed toward those truly in need. In the case of Medicaid, we will aid the states in restoring its financial integrity and its local direction.

We welcome the long-overdue emphasis upon preventive health care and physical fitness that is making Americans more aware than ever of their personal responsibility for good health. Today's enthusiasm and emphasis on staying well holds the promise of dramatically improved health and well-being in the decades ahead. Additionally, health

(continued on page 222)

Reprinted from the 1980 Platform of the Republican Party.

DEMOCRATS / Continued

Long Term Care. We must develop a new policy on long-term care for our elderly and disabled populations that controls the cost explosion and at the same time provides more humane care. We must establish alternatives to the present provisions for long-term care, including adequate support systems and physical and occupational therapy in the home and the community, to make it unnecessary to institutionalize people who could lead productive lives at home.

We must support legislation to expand home health care services under Medicare and other health programs. Visits from doctors, nurses and other health personnel are a cost-effective and necessary program for the elderly who often cannot travel to medical facilities. Without home health services, many elderly citizens would be forced to give up their homes and shift their lives to institutions.

Multilingual Needs. We must support the utilization of bilingual interpreters in English-Spanish and other appropriate languages at federal and state-supported health care facilities. In addition, we support broader, more comprehensive health care for migrants.

Health Care Personnel. This nation must maintain an adequate supply of health professionals and personnel. Particular emphasis should be given to programs which educate nurses and other health professionals and related personnel, especially for the traditionally underserved rural and inner city areas.

The rising cost of education in health fields bars many who wish to enter these fields from doing so. In order to expand representation in the health professions of traditionally underrepresented groups, we support programs of financial assistance such as capitation grants. These programs must increase the presence of men and minorities in nursing, and must be targeted toward women and minorities in other health professions.

Minority and Women Health Care Professionals. We recognize the need for a significant increase in the number of minority and women health care professionals. We are committed to placing greater emphasis on enrollment and retention of minorities and women in medical schools and related health education professional programs.

We are also committed to placing a greater emphasis on medical research and services to meet the needs of minorities, women and children.

Reproductive Rights. We fully recognize the religious and ethical concerns which many Americans have about abortion. We also recognize the belief of

many Americans that a woman has a right to choose whether and when to have a child.

The Democratic Party supports the 1973 Supreme Court decision on abortion rights as the law of the land and opposes any constitutional amendment to restrict or overturn that decision.

Furthermore, we pledge to support the right to be free of environment and worksite hazards to reproductive health of women and men.

We further pledge to work for programs to improve the health and safety of pregnancy and childbirth, including adequate prenatal care, family planning, counseling, and services, with special care to the needs of the poor, the isolated, the rural, and the young.

Financially Distressed Public Hospitals. Frequently, the only source of medical care for much of the inner city population is the public general hospital. The ever-increasing costs of providing high quality hospital services and the lack of insurance coverage for many of the patients served have jeopardized the financial stability of these institutions. Immediate support is required for financially distressed public hospitals that provide a major community service in urban and rural areas.

In underserved areas where public hospitals have already been closed because of financial difficulty, we must explore methods for returning the needed hospitals to active service.

We must develop financial stability for these hospitals. Our approach should stress system reforms to assure that more primary medical care is provided in freestanding community centers, while the hospital is used for referral services and hospitalization.

Medicaid Reimbursement. The Democratic Party supports programs to make the Medicaid reimbursement formula more equitable.

Unnecessary Prescriptions. We must reduce unnecessary prescribing of drugs and guarantee the quality and safety of products that reach the market through improved approval procedures.

REPUBLICANS / Continued

professionals, as well as individuals, have long recognized that preventing illness or injury is much less expensive than treating it. Therefore, preventive medicine combined with good personal health habits and health education, can make a major impact on the cost of health care. Employers and employees, unions and business associations, families, schools, and neighborhood groups all have important parts in what is becoming a national crusade for better living.

Mississippi State Medical Association Auxiliary

1980 AMA Auxiliary Convention

Have you taken a good look at yourself in a full length mirror lately? If the mere thought of such a thing fills you with despair, it's time for you to "Shape up for Life" with the AMA Auxiliary's physical fitness program. Begun last year with emphasis on "Food for Fitness," the program's second phase, fitness through regular exercise, was introduced this year at the national convention.

Guest speaker C. Carson Conrad, executive director, President's Council on Physical Fitness and Sports, stressed the importance of daily stretching exercises in addition to other organized sports. He pointed out that one strong motivation for regular exercise, other than looking better, is feeling better. He reminded AMA Auxiliary officers, delegates and guests that people who stay physically fit are less likely to suffer from back pain and other illnesses which plague the overweight and unfit. Complete details of the "Shape up for Life" program are available through your local auxiliary Health Projects Chairman or from your state auxiliary Health Projects Chairman, Mrs. Stanley Hartness, P.O. Box 569, Kosciusko, MS 39090.

The 1980 AMA Auxiliary convention began on Sunday, July 20, with the opening of the House of Delegates. The keynote address was given by Letitia Baldrige, well known author and White House social secretary during President Kennedy's administration. She also handled Mrs. Kennedy's public relations and accompanied the Kennedys on all state visits abroad. Needless to say, it was a treat to hear her speak and to meet and visit with her at the elegant reception which followed the opening session.

I was one of four delegates representing Mississippi. Other delegates were Mrs. Jim Barnett of Brookhaven, Mrs. John Estess of Hollandale, and Mrs. James Martin of Ocean Springs. We attended workshops in various auxiliary activities, as well as Reference Committee hearings which were conducted prior to the General Meeting.

"It is *your* work that makes progress possible," AMA Auxiliary president Mrs. Ben Johnson, Jr., told delegates at the General Meeting. She praised the auxiliary for progress in three areas: working with the medical profession, working with the community, and working with each other. She reported that the AMA Auxiliary has grown by 689 members to a total of 81,355 in 1980.

Officers elected by the AMA Auxiliary for 1980-81 include "our own" Jean Hill, wife of Dr. Edward Hill of Hollandale. This is the second year that Jean has been elected to the national board as one of two directors chosen from the Southern Region. We are grateful to Jean for representing our state so well.

★★★

MRS. CURTIS ROBERTS
President, MSMA Auxiliary





The President Speaking

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

What Choice?

As time draws near for the November election, it appears that the candidates draw closer and closer. At this writing the election is a toss-up. Some people are asking, "Can we stand four more years of Carter?" The other group is saying, "Can Reagan really run the country?" These are questions which the American voters will have to answer in November.

Elsewhere in this issue you will find the health care planks of the platforms of the Democratic and Republican parties. It appears to me that regardless of our party affiliation, there is actually no decision to make.

If we are really honest in our assessment of organized medicine and are satisfied with what we have been advocating and doing, then the Democratic menu cannot be palatable. We simply cannot digest any of the entrees which it offers. Certainly we could say that President Carter is trying to be a "Good Deed Dotty," for he is offering something for everyone. I am afraid that it would be at a price we could not afford — the service would be poor and the product cold. On the other hand, it is certainly not hard to understand the Republican plank. Who knows, maybe it was not written by intellectuals. In any event, I like what it says: namely, "Republicans unequivocally oppose socialized medicine, in whatever guise it is presented by the Democratic Party." That statement is clear.

The American people must be furnished good medical care at an affordable price. We should work to that end. I am sure we will have to give and take a little, but we must not waver too much. We must work hard and sacrifice a little if that is what it takes.

The AMA is sponsoring a campaign of voter registration and voter turnout, and is urging a good physician turnout at the polls. The slogan of the campaign is, "I'll be there." Let us all do our part.

★★★

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

VOLUME XXI, Number 10

OCTOBER 1980

It's That Time Again!

As the hot, dry summer comes to an end, with the first hint of fall in the air, the doctor-sportsman undergoes a metamorphosis known only to the world of nature. Fishing gear is laid aside and some irresistible urge turns his attention to guns and hunting.

The old favorite shotgun, neglected all summer, gets a grease and polish job, shells are inventoried, and hunting gear is checked. The telescopic site on his rifle gets zeroed in to three shots in a two-inch circle at 75 yards. All the while he dreams of an eight-point buck standing broadside in the early light of dawn. Visions of doves swarming over the grain field intermingle with dreams of flights of mallards, wings cupped, settling into the decoys.

He gives the faithful Lab a loving pat on the head and maybe a quick review in sit, stay, and fetch. His loving wife, totally unable to comprehend this strange illness, gives a long sigh of resignation. Come what may, she will welcome him back from the hunt — cold, wet, and hungry, realizing that some inner desire has been fulfilled and tranquility reigns.

It's great to live in Mississippi during the hunting season. Winter will be gone before you know it, and spring is just around the corner; but, then, there is always the turkey season!

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

Medico-Legal Brief

Family Can Discontinue Elderly Patient's Hemodialysis

A patient's physician and family should decide whether to continue hemodialysis treatments for the elderly patient, a Massachusetts appellate court ruled.

The patient, who was born in 1901, was a retired chief chemist and metallurgist at a tool and die plant. He was an outdoorsman and an avid hunter and fisherman. He retired in 1966, and traveled with his wife for a period of years before the onset of the

illnesses. Because of kidney failure, he began dialysis treatments in February 1978. He returned home and began thrice-weekly treatments at a private kidney center for the end-stage renal disease.

At the outset of this period, the patient was showing signs of mental disorientation. His behavior at home became somewhat belligerent and destructive and he was unable to care for himself. A psychiatrist diagnosed his condition as chronic organic brain syndrome. By January 1979, he was no longer able to recognize his wife and son.

The wife and son petitioned the Probate Court for an order that hemodialysis treatment be terminated. The court appointed a guardian ad litem, who opposed the order. The court entered a judgment directing that the treating physician, the wife and the son make the decision whether dialysis treatments were to be continued.

On appeal by the guardian ad litem, the appellate court affirmed the decision. The evidence justified a finding that the patient would wish to have dialysis terminated under the circumstances. He was not a suitable candidate for a kidney transplant, his remaining days were to be spent in an irreversible state of dementia, and the physician supported the family's view that further treatment was inappropriate, the court noted. The state's general interest in the preservation of life was not sufficient to warrant intervention in the treatment decision, the court concluded. — *In the Matter of Spring*, 399 N.E.2d 493 (Mass. App.Ct., Dec. 21, 1979)

113th Annual Session

April 26-30, 1981
Biloxi Hilton

- 14 scientific section programs
- specialty society meetings
- medical alumni activities
- House of Delegates

Plan now to attend!

PRACTICE MANAGEMENT MAILBOX

Physicians' Fees and Charges — Ethical Considerations

Everyone knows that charging an excessive fee is unethical; that a physician's fee should be commensurate with the services rendered and the patient's ability to pay. However, there are many other ethical considerations relating to physician's fees and charges. The following paragraphs are taken from the AMA Judicial Council's *Opinions and Reports* and represent some of the Council's interpretations of the Principles of Medical Ethics. They are intended to help you, the physician, as well as your office staff in meeting your ethical responsibilities in the fees and charges made to your patients.

Charging for a missed appointment or for one not cancelled 24 hours in advance need not, in itself, be considered unethical if the patient is fully advised that the physician will make such a charge. The practice, however, should be resorted to infrequently and always with the utmost consideration of the patient and his circumstances.

The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee, or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

The physician's ethical responsibilities in referring a delinquent account to a collection agency should include the following. He should first give due consideration to the patient's ability to pay the fee which is due. Secondly, he should not utilize the services of a collection agency whose tactics and methods of collection might be unfair or abusive. The physician may not "sell" his delinquent accounts to a collection agency and may not enter into any arrangement under which the physician would lose complete control of the delinquent account or the method of its collection.

The attending physician should complete without charge the appropriate "simplified" Health Insurance Council forms and similar insurance claim forms as a part of his service to the patient to enable the patient to receive his benefits.

A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion.

It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note, or to charge a penalty on fees for professional services not paid within a prescribed period of time, or to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. The patient must be notified in advance of the existence of this practice.

Medical reports should not be withheld because of an unpaid bill for medical services. Simplified, routine forms can be prepared without charge, but a charge for more complex, complicated reports may be made in conformity with local custom.

In an effort to render proper service to your patients, please pass this information along to your office staff.

(This month's article was prepared by Bucky Murphy, MSMA general counsel. Please address your practice management inquiries to P.O. Box 5229, Jackson, MS 39216.)

LETTERS

SIRS: As a regular and thorough reader of the MSMA JOURNAL, the recent return to the plain red and black cover was in stark contrast with the warm and personal appearance of the June and July editions.

Unless the cost-benefit ratios are prohibitive, in which case I suggest we switch to a plain manila folder, the June and July issues are more attractive on my desk and in the waiting room or as framed works of art, and cause me to suggest that we keep the June and July format.

I appreciate all your work as editors, and thought that I would let you know, I do read the JOURNAL.

GEORGE V. SMITH, M.D., FACS
1072 Flynt Drive, Suite C
Jackson, MS 39208

MEDICAL ORGANIZATION

Board Invites Nominations For MSMA-Robins Award

The 20th annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1981 award will be presented at the 113th Annual Session during closing ceremonies on April 30.

Dr. Paul H. Moore, president, and Dr. Sidney Graves, chairman of the Board of Trustees, said that each component medical society has been invited to submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, VA, a long-established manufacturer of ethical pharmaceuticals.

Nominees must be members of the state medical association, according to Drs. Moore and Graves, and the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in the connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities

in a civic, cultural, or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Moore and Graves said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be re-submitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1981. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 19 Mississippi physicians who have received the high honor are: Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by Northeast Missis-

AMA Delegates Discuss Health Care Issues During Radio Interviews



Dr. James O. Gilmore of Oxford, left, and Dr. W. Lamar Weems of Jackson, MSMA's delegates to the AMA, were among some 110 AMA members who participated in radio interviews while attending the recent 129th Annual Session in Chicago. Each interview was distributed within 24 hours to radio stations in the delegate's hometown. Interviews focused on subjects such as the impact of inflation and unemployment on the patient's ability to pay for medical care, cost containment, preventive medicine, trends toward primary care, and the impaired physician. The expected audience listenership is expected to exceed those estimated figures resulting from the same project at the AMA's Interim Meeting in Honolulu, when more than 41,071,938 listeners heard similar interviews with AMA delegates.

ROBINS AWARD / Continued

Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, Delta Medical Society, 1964; Dr. Maura J. Mitchell of Ellisville, South Mississippi Medical Society, 1965; Dr. J. T. Davis of Corinth, Northeast Mississippi Medical Society, 1966; Dr. Frank M. Acree of Greenville, Delta Medical, 1967; Dr. W. H. Anderson of Booneville, Northeast Medical Society, 1968;

Dr. Omar Simmons of Newton, East Mississippi Medical Society, 1969; Dr. W. J. Aycock of Calhoun City, Northeast Society, 1970; Dr. Walter H. Rose of Indianola, Delta Medical Society, 1971; Dr. Reginald P. White of Meridian, East Mississippi Medical Society, 1972; Dr. W. A. Long, Jr., of Jackson, Central Medical Society, 1973; Dr. Virginia S. Tolbert of Ruleville, Delta Medical Society, 1974; Dr. Thomas M. Davis of Jackson, Central Medical Society, 1975;

Dr. Thomas G. Barnes of Greenville, Delta Medical Society, 1976; Dr. Hugh Banks Barnes of Hattiesburg, South Mississippi Medical Society, 1977; Dr. Verner S. Holmes of McComb, South Central Medical Society, 1978; Dr. W. L. Jaquith of Jackson, Central Medical Society, 1979; and Dr. Jack A. Atkinson of Brookhaven, South Central Medical Society, 1980.

AMA Plugs PSRO Program

The Professional Standards Review Organization (PSRO) program for Medicare-Medicaid should be allowed to develop to its full potential, the American Medical Association has told Congress.

The medical profession has accepted PSRO as a quality assurance program. "Therefore, we feel that it is inappropriate to evaluate the program solely based on a measure of dollars and cents."

Alan Nelson, M.D., a member of the AMA Board of Trustees, told the House Ways and Means subcommittee on Health that the PSRO program is a successful example of cooperation between the medical profession and the federal government. Some 167,000 physicians are participating, Dr. Nelson noted.

One of the problems with PSRO since its inception in 1972 has been the tendency of administrations, Democratic and Republican, to eye the program as one strictly designed to save money. There have been crisis points in recent years when PSRO

was believed to be in jeopardy because of high-level belief that it was costing more than it was saving.

Dr. Nelson pointed out to the subcommittee that the PSRO law declares it is designed to "promote the effective, efficient and economical delivery of health care services of proper quality."

There have been numerous analyses in recent years of the cost-effectiveness of PSRO. The two most recent, by the Health Care Financing Administration (HCFA) and the Congressional Budget Office (CBO), used the same data base but reached opposite conclusions. The CBO said PSROs were not cost effective. HCFA said that in fiscal year 1978 they saved \$21 million.

"Because of this divergence in interpreting the PSRO program data and the fact that PSRO effectiveness should be reviewed by means other than just cost-effectiveness, the AMA views such single directional analysis as impractical," said Dr. Nelson. The matter is especially critical now, he added, because the Health and Human Services (HHS) Department has started to terminate PSROs that it deems to be "poorly performing and cost-ineffective."

It is premature to attempt to measure the cost-effectiveness of the PSRO program, Dr. Nelson said, adding that "the PSRO program has been consistently underfunded, with some PSROs not even receiving all of the funds necessary to properly design and subsequently implement the sophisticated review and data collection operations essential to conduct a proper review program. Until the program becomes fully operational, it is a mistake to attempt to ascertain its cost-effectiveness."

1500 Students Register For UMC's Fall Term

More than 1500 students, including 602 medical students, registered for classes at the University of Mississippi Medical Center this fall.

The new first-year medical students represent some 68 Mississippi communities.

The Medical Center marks its 25th anniversary this year. The state's only health sciences campus opened in 1955 with 166 students enrolled in the School of Medicine and the graduate programs. The 1980-1981 enrollment figure includes students in the Schools of Medicine, Nursing, Health Related Professions and Dentistry; graduate students in the basic sciences; and students in various certificate programs.

State's Hospital Rates Lowest in Nation

Mississippi's hospital room rates, averaging \$65 per day for a semiprivate room, are the lowest in the country, according to figures from a recent survey conducted by the Health Insurance Association of America.

The survey included responses from 3,091 non-governmental short-term hospitals across the country. As of January 1980, the national average daily cost to the patient for a semiprivate room was \$127, a 20.8% increase in two years.

Generally, persons living in the Northeast pay the highest average rate, at \$143, while persons in the South pay an average of \$101. But rates in each region can vary dramatically.

In the Northwest, for example, the average in Alaska is \$189 a day, 51% higher than in Washington, where the rate is \$125. In the South, Oklahoma's average rate is \$102, 57% higher than Mississippi's.

The greatest percentage increases in the last six months of 1979 were in South Dakota, up 11.6%; Oklahoma, up 10.9%; Nevada, up 10.6%; and the District of Columbia, up 10.4%. Only Delaware's average of \$125 did not increase during the six-month period.

Mississippi's average rate of \$65 was up from \$59 in July 1979. A review of other Southern states shows that Alabama's rate in January was \$96, up from \$91 in July 1979; Arkansas, \$86 — up from \$79; Georgia, \$93 — up from \$88; Louisiana, \$90 — up from \$87; Kentucky, \$90 — up from \$84; Tennessee, \$92 — up from \$86; Texas, \$92 — up from \$86.

The Health Insurance Institute reports that some 181 million Americans have hospital expense insurance to help pay for room and board expenses.

Dr. Batson Nominated for VP, American Academy of Pediatrics

Dr. Blair E. Batson, professor and chairman of the Department of Pediatrics at the University of Mississippi School of Medicine, is one of three nominees for the post of vice president (president-elect) of the American Academy of Pediatrics. The election will take place during the Academy's 50th Anniversary Meeting in Detroit later this month.



Dr. Batson

Currently chairman of AAP's District VII, Dr. Batson has held numerous posts in the Academy, including chairman of the Finance Committee, chairman of the Executive Board's advisory committee on committees, a member of the Sub-Committee on Title V Legislation and the new Task Force on Federal Office of Maternal, Child and Adolescent Health. He is a past chairman of Board committees on chapters and membership, operations, and regionalization of perinatal care, among others.

On the Mississippi level, Dr. Batson has long been involved in a variety of health projects, including most recently the Governor's Committee on Children and Youth. He also worked on the Community Health Improvement Project, a rural outreach program, as consultant from 1966-78 and as director from 1974-78.

Among the awards presented to Dr. Batson in recognition of his work on behalf of children are an award from the Mississippi Chapter of the AAP for "Leadership and Devotion to Child Health Care in Mississippi," and outstanding service awards from the National Easter Seal Society and the March of Dimes.

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DR. BATSON NOMINATED / Continued

Dr. Batson is a member of the Mississippi State Medical Association, the American Medical Association, the American Pediatric Society, the American Public Health Association, and other national, state and local professional organizations.

He has held his present post at the University of Mississippi since 1955, as the first and only chairman of the Department of Pediatrics. Before that, he held teaching positions in pediatrics at Vanderbilt University and in pediatrics and public health administration at Johns Hopkins University.

He received his M.D. Degree from the Vanderbilt University School of Medicine in 1944, and an M.P.H. degree from Johns Hopkins University School of Hygiene and Public Health in 1954. He interned at Vanderbilt University Hospital and took residency training there and at Johns Hopkins University Hospital.

DEATHS

HARRELL, FELIX JAMES, JR., Biloxi. Born Timpson, TX, Dec. 8, 1907; M.D., Baylor College of Medicine, Houston, TX, 1930; interned Baptist Hospital, New Orleans, one year; died July 19, 1980, age 73.

OWEN, GEORGE W., Jackson. Born Memphis, TN, April 24, 1894; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1921; interned St. Thomas Hospital, Nashville, one year; allergy resident, Sanders Clinic, Memphis, 1923-25; member of Fifty Year Club MSMA; died June 28, 1980; age 86.

RAYNER, HUGH S., JR., Meridian. Born Eutaw, AL, Dec. 1, 1921; M.D., Northwestern University Medical School, Chicago, 1951; interned Charity Hospital, New Orleans, one year; surgery residency, Ochsner Foundation Hospital, New Orleans, 1954-58; died Aug. 9, 1980, age 60.

SHIPP, JOHN MARTIN, Yazoo City. Born Benton, MS, Dec. 19, 1888; M.D., American Medical College, Indianapolis, IN, 1913; interned Vanderbilt Hospital, Nashville, TN, one year; died Aug. 7, 1980, age 91.

JOIN



TODAY

PERSONALS

GEORGE E. ABRAHAM, II, and JOHN ROBERT FORD of Vicksburg announce the relocation of their offices to 1907 Mission 66.

GEORGE L. ARRINGTON of Meridian has been elected as Chief of Staff at Jeff Anderson Memorial Hospital.

T. J. BARKLEY and JOHN S. BARR of Belzoni announce the association of T. SCOTT McCAY for the practice of medicine.

JACK C. BIGGS and LELAND R. CORNELIUS of Southaven announce the association of ROBERT JAMES BURNETT for the practice of medicine and surgery.

DAVID BURNETT announces the opening of his office for family practice at the Andrews Building in Purvis.

JANIS E. BURNS of Tupelo has relocated her office for the practice of plastic and reconstructive surgery to 1040 S. Madison.

DAVID CARNER has opened his practice of general and vascular surgery with offices in the Medical Arts Building on N. Jackson Street in Brookhaven.

WILLIAM A. DAVIS has opened his office for the practice of general medicine at the West Point Family Clinic, 330 W. Broad Street in West Point.

MICHAEL R. DUCKWORTH has opened his office for practice of internal medicine at Moore's Creek Office Plaza, Suite 1, in Columbus.

RUSSEL G. CHAUVIN has relocated his office for the practice of general surgery to 516 W. Canal Street in Picayune.

PATRICK A. DUFFY announces the opening of his office for the practice of ophthalmology at 151 Jefferson Davis Boulevard, Suite B, in Natchez.

JOHN F. EGGER, JR. has associated with DEWITT T. BROCK, JR. of Jackson for the practice of colon and rectal surgery.

HOWARD W. ELLZEY announces the opening of his office for general practice in Suite 248, Panola Plaza, Batesville.

DAVID S. JOE has associated with Durfey Clinic, 1360 E. Peace Street, in Canton, for the practice of family medicine.

THOMAS E. GOYER of Iuka announces the relocation of his office for the practice of general surgery to Medical Arts Building, Suite 240.

JOHN E. HARRIS announces the opening of his office for family practice at 119 Robertson Street in Okolona.

MARTIN HERMAN has opened his office for the practice of pediatrics in Fulton.

WILLIAM M. HILBUN, JR. of Tupelo announces the association of EDWARD IVANICIC for the practice of pediatrics at the Pediatric Clinic, 820 Ridgecrest.

SAMUEL B. JOHNSON of Jackson and UMC conducted a course in tonometry in Biloxi in July.

HERBERT LANGFORD of Jackson and UMC spoke at a medical staff meeting at Johnston-Willis Hospital in Richmond, VA, in August.

JOHN W. MCFADDEN announces the opening of his office for the practice of family medicine at 810 Garfield Street in Tupelo.

JOHN C. MORRISON of Jackson and UMC was guest speaker at the National Symposium on Perinatal Nursing in Montreal, Canada, August 7-10.

RICHARD A. NICHOLS and EDWARD S. HOFFMAN of Pascagoula announce the association of REBECCA D. SHAW for the practice of gynecology and obstetrics.

LEON C. PARKS and GEORGE V. SMITH announce the opening of their offices for the practice of surgical oncology at 1072 Flynt Drive, Suite C, in Jackson.

RICHARD W. PHARR announces the opening of his office for the practice of ophthalmology at Rankin Professional Building, 348 Crossroads Boulevard, in Brandon.

DEBRA SAVAGE RODGERS has opened her office for the practice of psychiatry at 1052 Riverside Plaza in Jackson.

DAVID B. SHUCK has opened his office for the general practice of medicine and obstetrics at the Neshoba County Family Clinic, 913 Holland Avenue, Philadelphia.

CHARLES STERN of Natchez announces the relocation of his office for the practice of ophthalmology to 151 Jefferson Davis Boulevard.

RICHARD H. STREIFFER and WILLIAM E. WALKER have opened offices in Collins at Fourth Street South for the practice of family medicine.

PERSONALS / Continued

BERTRAND O. SY announces the opening of his office for the practice of pediatrics at 310 Highway 90 East in Bay St. Louis.

ROBERT S. TURNER, JR. has joined the anesthesiology department of King's Daughters Hospital in Brookhaven.

HENRY B. TYLER of Jackson has been named a Fellow of the American College of Cardiology.

WINFRED WISER of Jackson and UMC lectured at the Mobile Bay Obstetrical and Gynecological Society in Mobile AL, in July.

PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

PHYSICIANS WANTED TO RENT OR LEASE completely furnished 14-room modern clinic in county seat with population 15,000. New 36-bed hospital and 60-bed nursing home. Ill health caused physician to vacate clinic after 25 years successful practice. Call (601) 326-2741 between 8:00 a.m.-6:00 p.m.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

GENERAL PRACTICE opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

BOARD ELIGIBLE OB-GYN concluding 4-year Ob-Gyn residency July 1 seeking solo, association or partnership position in semi-rural area of Southeast. Contact: James D. Long, M.D., 131 Beverly Ave., Norfolk, VA 23505.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

FAMILY PHYSICIAN seeking a group practice opportunity in Mississippi. Graduate of Mississippi College and University of Mississippi School of Medicine, (1978). Presently serving residency at Roanoke Memorial Hospital. Contact Robert C. Lee, M.D. 2325 Avenham Ave., Apt. #6, Roanoke, VA 24014, or call 703/344-3506.

LOCUM TENENS work wanted — family and general practice, open availability. Contact T. C. Kolff, M.D., (801) 566-1666.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar De-Sai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

CLASSIFIED

PHYSICIANS WANTED. Pediatric and/or family practice physician wanted to help staff Hinds County Health Department Clinic. Ob-Gyn, pediatrician or family practitioners needed to staff health department clinics in areas outside Jackson area. Contact Dr. C. E. Fox, P. O. Box 1700, Jackson, MS 39205 or call (601) 354-6680.

OFFICE FOR LEASE (2,000 sq. ft., available July 1, 1981). Located in professional area of Tupelo, across street from 600-bed North Mississippi Medical Center. Family practitioners or other interested physicians, please contact Frank C. Baker, D.D.S., 810 Garfield Dr., Tupelo, MS 38801 or telephone 601/842-8035 (office) or 601/842-5224 (home).

EQUIPMENT FOR SALE. GE diagnostic x-ray machine, model 39; Burdick EKG; Clay Adams hematocrit centrifuge; examining table; instrument cabinet. Contact Dr. L. G. Carl, Jackson, MS, 366-8494 (office) or 366-3710 (home).

Index to Advertisers

American Medical Association	18	Merrell-National, Inc.	14, 14A
Boeringer Ingelheim	14B, 14C, 14D	Miss. Medical Fraternal and Educational Society	219
Boots Pharmaceuticals	6A, 6B, 6C, 6D	Parke Davis & Co.	8
Burroughs Wellcome	12	Premier Printing	216
Canton Exchange Bank	218	Riverside Hospital	7
Citizens Bank	213	Roche Laboratories ..	second, third and fourth covers, 3, 4
Darkroom, Inc.	229	South Central Bell	17
Harreld Chevrolet	213	U. S. Army	15
Eli Lilly and Company	10	Wyeth Laboratories	10A, 10B, 230
		Thomas Yates and Company	6

IN CONCLUSION

The Graduate Medical Education National Advisory Committee (GMENAC), predicting a surplus of physicians by 1990, recommends that economic incentives be used to expand under-supplied specialties and to encourage practicing in underserved areas. Some 19 major specialties are predicted to have surpluses. Another suggestion is to reduce medical school enrollments. Although GMENAC lacks power to enforce its suggested quotas, the panel's recommendations to HHS are expected to have an impact on health manpower policy.

The Office of the Assistant Secretary of Health has asked the Institute of Medicine to examine almost 300 federal health services created over the past decade to determine efficient approaches. The two-year study will document programs by federal agencies and analyze selected service agencies. The Office of Management and Budget's Catalogue of Federal Domestic Assistance lists 1,078 programs administered by 57 federal agencies, 289 of them under the category of health and medical services.

Lectures entitled "Does the Dawn of Genetic Engineering Herald a Golden Age in Medicine?" and "Endorphins and Beyond: The Future of Brain Hormones in Clinical Medicine" will be among special distinguished lecture topics at the AMA's Winter Scientific Meeting, Jan. 24-26 in Atlanta. Other study areas include infectious disease, problems facing the American family, drug therapy, gastrointestinal disease, heart disease, pulmonary disease, nuclear medicine, bowel disease and viral infections.

Abbott Laboratories has termed more "political than scientific" the FDA's latest 311-page denial of the company's petition to return cyclamate sweeteners to the U.S. market, and says it will not appeal because "it would be useless" to continue the seven-year effort. A spokesman said the decision imposes standards of safety that have never been required before and which are impossible to establish scientifically, and charged that the decision "makes uncertain the future of a number of widely used and necessary ingredients in our food supply."

A group of the nation's leading eye specialists have cautioned that radial keratotomy is still experimental and by no means ready yet for general use. In the Archives of Ophthalmology, the group notes that it is unknown which patients will benefit and what effect the operation has after many years. An accompanying editorial declares, "Caution must be exercised to prevent the proliferation of this operation before its efficacy and safety are established by careful studies."

OCT 17 1980

NEW YORK ACADEMY
OF MEDICINE



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disorders and as
an adjunct
in the relief
of skeletal
muscle spasm

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect.

Adults: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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of skeletal muscle spasm.

Please see summary
of product information
on preceding page.



November 1980

BALCONY

Journal of the
State Medical
Association

Mississippi

(ISSN 0026-6396)

Contents:

Management of
Thoracic Duct Fistula

Colon Obstruction
Secondary To
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Splenomegaly

Superior Mesenteric
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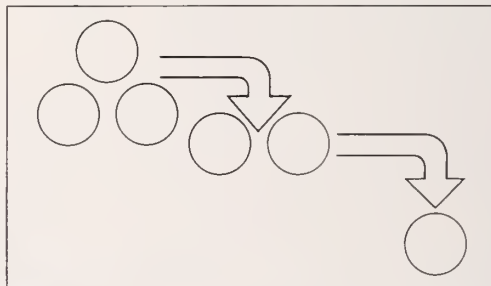
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*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



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efficient pharmacodynamics*

Before prescribing, please see summary of product information on next page



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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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CONTENTS

ORIGINAL PAPERS

Management of Thoracic 233 MICHAEL D. MAPLES, M.D.,
Duct Fistula MARTIN H. McMULLAN, M.D.,
and THOMAS L. KILGORE, M.D.

Colon Obstruction Secondary 237 RALPH H. DIDLAKE, M.D.,
To Adhesive Splenomegaly HARVEY I. PASS, M.D.,
and SESHADRI RAJU, M.D.

SPECIAL ARTICLE

Radiologic Seminar CCVIII: 240 JAMES L. BURKHALTER, MD.
Superior Mesenteric Artery and
Syndrome BERNARD I. BLUMENTHAL, M.D.

EDITORIALS

It's Your Responsibility 245 BURKE C. MURPHY, JR.

Usual, Customary and 245 J. WILLIAM WRIGHT, M.D.
Reasonable Fees

THIS MONTH

The President Speaking 244 Are You Involved?

Practice Management 247 How Long Are Your Patients
Mailbox Waiting?

Medical Organization 248 Former HMO Medical Director
Describes Experiences

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Sharp Increase Reported In Illicit Drug Use

Illicit drug use has increased sharply in the past 20 years, especially among young adults, according to two studies for the government.

The proportion of people who have used marijuana has increased from 4% to 68%. Harder drugs — cocaine, heroin, hallucinogens, or inhalants — have been tried by 33% of 18-to 25-year-olds.

The studies show that between 1972 and 1979, experience with marijuana and cocaine has doubled among young teenagers and among those over 25 years of age. Between ages 18 and 25, cocaine use has tripled and marijuana use has increased from 48% to 68%.

The illicit use of stimulants, sedatives and tranquilizers reported by 12-to 17-year-olds and those over age 25 has remained relatively constant over the last decade. However, these drugs showed large increases by 18-to 25-year-olds until 1977. Experience with heroin has been constant during the 1970s with about 3% or less reporting they have tried it.

1979 Health Expenditures Up, Says Government Report

The nation last year spent an estimated \$212.2 billion for health care, 12.5% above 1978, the government has reported.

The 1979 health spending amounted to an estimated \$943 per person. Of that amount, \$406 or 43%, represented public spending.

The latest comprehensive health spending estimates were compiled by the Health Care Financing Administration (HCFA) and show that outlays by Medicare and Medicaid amounted to \$29.3 billion and \$21.7 billion respectively, combining to pay for 27% of all personal health care in the nation. Benefits for hospital care alone amounted to \$29.7 billion for both programs.

Other highlights of the report include the following:

Expenditures for health care included \$54.4 billion in premiums to private health insurance, \$60.9 billion in federal payments and \$30.5 billion in state and local government funds.

The \$85.3 billion bill for hospital care represented 40% of total health care spending in 1979. These expenditures increased 12.5% over 1978.

Spending for physician services increased 13.4% to \$40.6 billion—19% of all health care spending. All third parties combined — private health insurers, governments, philanthropic and industry — financed 68% of the \$188.6 billion in personal health care in 1979, ranging from 92% of hospital care services to 64% of physician's services and 39% of the remainder.

Direct payments by consumers reached \$60 billion in 1979. This represented 32% of all personal health care expenses.

Thyroid Supplements Vary Widely in Potency

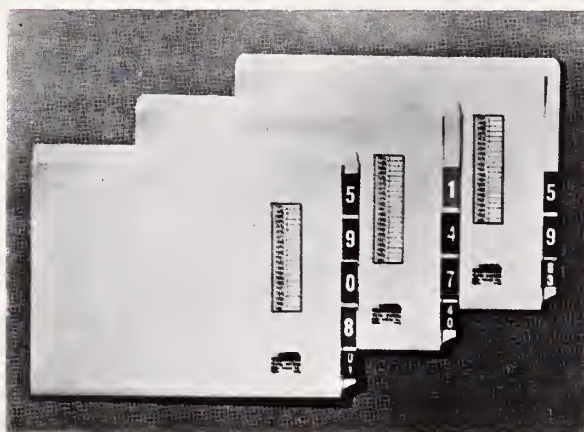
Different brands of a thyroid supplement can vary considerably in potency, says a report in the Oct. 10 issue of JAMA.

An analysis of a brand name thyroxine tablet and two generic products, supposedly the same, revealed that the thyroxine content was significantly different.

The reporting physician concluded that manufacturers should be required to measure the thyroxine content and that generic substitution should not be done until the products become more uniform.

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(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlori-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood and in near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery. Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. The response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), encephalitis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and resumption of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication

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Philadelphia, Pa 19101



FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in one tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group. **PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, naltrexone, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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We are looking for dedicated physicians, physicians who want to be, not salesmen, accountants, and lawyers, but physicians. For such physicians, we offer a practice that is practically perfect, where in almost no time you experience a spectrum of cases some physicians do not encounter in a lifetime, where you work without worrying whether the patient can pay or you will be paid, and where you prescribe, not the least care, nor the most defensive care, but the best care.

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#1 prescribed hemorrhoidal product

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IN 1959

AND IT STILL IS...

The professional source of
modern anorectal comfort

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Hemorrhoidal Suppositories

ANUSOL-HC[®] CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults. Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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PARKE-DAVIS

Div of Warner-Lambert Co
Morris Plains, NJ 07950 USA

2/80

NEWSLETTER

November 1980

Dear Doctor:

The move toward deinstitutionalization of mental health patients has presented particular challenges to mental health personnel and to communities throughout the nation. Patients released after years of institutional care have special transitional living and treatment needs, and detailed screening and referral mechanisms are necessary to coordinate delivery of services in the community, say mental health specialists.

Four special task forces have been assembled to study how to best meet the needs of these mental health patients in Mississippi. Focus will be on patient-related communications, public information, liaison between hospital and community programs, and transitional living arrangements.

The AMA Council on Legislation will begin an in-depth study to determine the need for changes in the National Health Service Corps program. AMA supports a bill for increasing NHSC funding, but wants emphasis on Corps personnel fulfilling their obligations in shortage areas in a private practice mode which encourages long-term service.

A recent Gallup Organization public opinion survey commissioned by the American College of Surgeons indicates that surgeons enjoy an extremely positive image among the general public. Little confidence in business executives and Congressmen was expressed by the majority, but a great deal of confidence in surgeons, family doctors and dentists was demonstrated.

Patient package inserts for ten drugs (benzodiazepines, propoxyphene, cimetidine, ampicillins, clofibrate, digoxin, methoxsalen, thiazides, phenytoin and warfarin) will be distributed by physicians and pharmacists beginning the middle of next year. The cost to drug manufacturers for producing the inserts to comply with FDA rules is estimated to be some \$21 million.

Nearly 80% of the American public is unfamiliar with HMOs and half of those eligible to join don't think they qualify, according to a new national survey by Lou Harris and Associates. The survey found that 92% of those currently enrolled in HMOs intend to renew their memberships and 57% said they are "highly satisfied." The report concludes that HMO growth will depend on marketing to employers.

Sincerely,



Patsy Silver
Managing Editor

Manage your patient time for quality care. Manage your practice for greater efficiency.

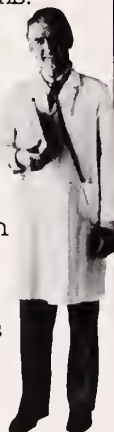
A medical practice is communications intensive. Bell – at the forefront of communications knowledge – offers systems and services to help you make more and better use of your doctor-patient time. And increase staff productivity by increasing efficiency in office procedures.



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Numerous practice management problems are fundamentally related to communications. It takes an average of 75 information exchanges, verbal and on paper, involving doctors, patients, office personnel, hospitals, outside providers, to move each patient from appointment scheduling through payment processing. Bell communications systems can help you manage these exchanges more effectively.



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Improve staff coordination.

Eliminate time-consuming footwork. Bell communications systems can provide instant inter-office consultation, personnel tracking, patient location.

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Recapture lost-to-error billings. Reduce turn-around time on third party reimbursements. Relieve the paperwork burden. Bell data terminals such as the Dataspeed® 40 will access a computer or service bureau to provide quick and accurate recording and retrieval of billing and claims information.

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Bell offers medical-oriented seminars to show you how the latest communications technology and techniques can improve your practice management procedures. In one short, enlightening forum, you'll gain valuable information to help you improve practice profitability. And you'll earn Category 2 CME credit.

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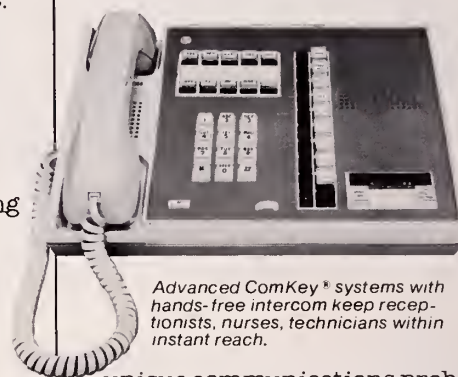
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Adjunctive Librax[®]

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer*
and irritable bowel syndrome*

Librax[®]

Please consult complete prescribing information, a summary of which follows:

*

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addicts.

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug.

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

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Motrin[®] vs codeine...

ibuprofen



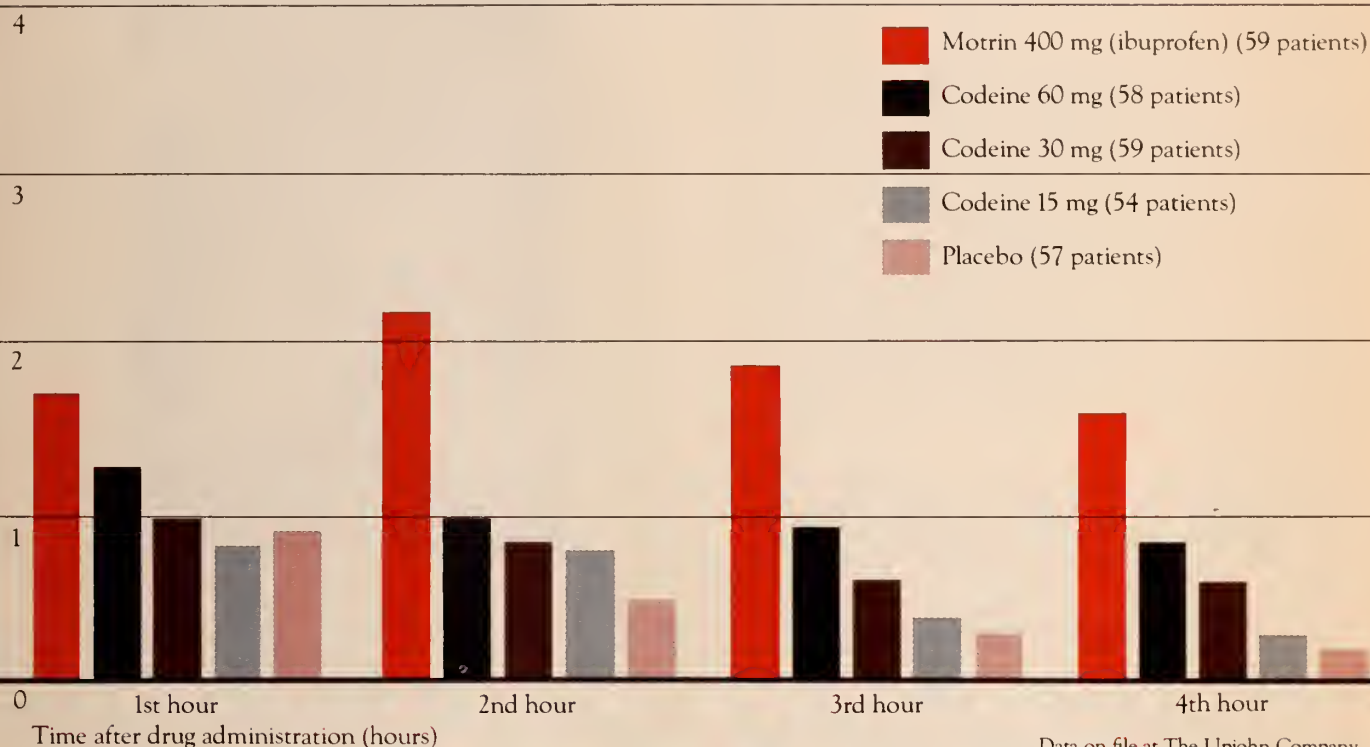
compare the analgesic effect

Motrin (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients.

Motrin was significantly more effective ($p < 0.01$) than codeine 60 mg at the 2-, 3- and 4-hour intervals...significantly more effective ($p < 0.01$) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

Degree of pain relief—mean scores

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn pain

A well-tolerated, nonnarcotic prescription for mild to moderate pain

Motrin[®] 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Acts peripherally
- Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
- The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin[®] (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

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University Medical Center Adds to Faculty

Six new faculty members have joined the School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

The new School of Medicine faculty members are Dr. Wood C. Hiatt, associate professor of psychiatry and human behavior; Dr. Subba Rao Dhannavada, assistant professor of surgery (research); Dr. Karen J. Houston, instructor in medicine (research); and Marcella Long McKay, instructor in obstetrics and gynecology. Joining the centerwide faculty are Dr. Jerry M. Farley, assistant professor of pharmacology and toxicology and Dr. Alice Barrieux, instructor in biochemistry.

Dr. Hiatt, on the University of Tennessee Center for the Health Sciences faculty from 1971-1976, earned the B.S. degree at the University of Alabama. He earned the M.D. degree and took residency training in general psychiatry at the University of Tennessee School of Medicine. He also took a residency in child psychiatry and pediatrics at Johns Hopkins University College of Medicine. He was chief of the child psychiatry section at the JFK Child Development Center in Memphis from 1969-1971.

Dr. Dhannavada has been immunologist and technical director of the transplantation immunology laboratory for the UMC renal transplant program since 1978. He earned the B.S. degree at Andhra University in India and holds the M.S. and Ph.D. degrees from Mississippi State University. He was a Public Health Service postdoctoral research fellow at MSU from 1972-1973 and research associate in immunology there from 1974-1976.

Dr. Houston, director of the oncology laboratory in the UMC Department of Medicine since 1979, is a former postdoctoral fellow in microbiology and instructor in biochemistry at UMC. Dr. Houston earned the B.A. degree at Mississippi University for Women, the M.S. degree at Ole Miss and the Ph.D. degree at the Medical Center.

Ms. McKay, an instructor in the Mississippi College School of Nursing since 1978, is former coordinator of nurse education for the Department of Obstetrics and Gynecology at the University of Tennessee Center for the Health Sciences. She earned the master of sciences in nursing degree at the Medical Center and holds the B.S., A.D.N., B.S.N. and

M.Ed. degrees from Mississippi University for Women.

Dr. Farley, research associate at Northwestern University School of Medicine since September, 1979, earned the B.A. degree at Miami University and the Ph.D. degree at West Virginia University.

Dr. Barrieux, assistant research endocrinologist at the University of California at San Diego since 1975, holds the M.S. and Ph.D. degrees from Northwestern University. A graduate of Maison d'Education de la Legion d'Honneur, Dr. Barrieux was an American Cancer Society Fellow at the University of California at San Diego School of Medicine Division of Endocrinology from 1970-1975.

AMA Schedules Sports Medicine Conference

The 22nd National Conference on the Medical Aspects of Sports will be held at the Atlanta Hilton Hotel, Atlanta, GA on Jan. 24, 1981. General sessions include Facial and Oral Related Injuries in Sports, Nutrition Relating to the Athlete, and Knee Pain in the Athlete.

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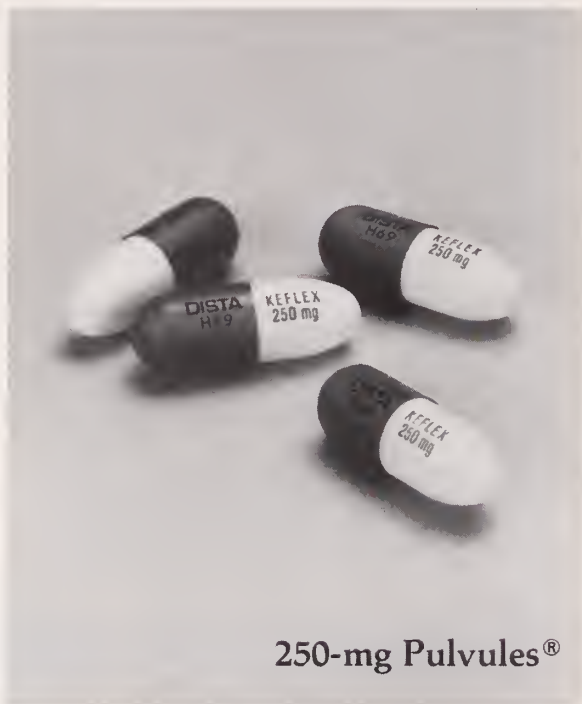
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DATELINE

Physicians Exonerated In Landmark Case

Corinth, MS - Two physicians were exonerated recently in a landmark breach of contract suit in Alcorn County. Judge Fred Wicker handed down

a directed verdict in favor of the physicians. Plaintiff charged no malpractice, but claimed verbal guarantees had been made. The judge pointed to Supreme Court decisions prohibiting the use of verbal evidence to refute written. (The patient had signed a consent form certifying no guarantees had been made.)

Subtle Violence Needs MD Intervention

New Orleans, LA - Physicians are in a favorable position to intervene usefully in many cases of "subtle violence" prevalent in family behavior,

said a Canadian family physician at the recent scientific assembly of the AAFP. While communities are dealing with obvious violence such as battered wives and abused children, he said, doctors can help in less obvious abuse such as nutritional, educational and social neglect of young or old dependents.

New Consumer Health Information Book

Chicago, IL - Patients may be asking about the Handbook of First Aid and Emergency Care, now available at bookstores. The book is the first

in the AMA's Home Health Library series. Future volumes will cover such topics as cardiovascular disease, women's health care, and back problems. Stressing prevention and the improvement of health habits, the books are designed to provide lay readers with authoritative medical information.

Physicians' Fees Trail Inflation Rate

Chicago, IL - The rate of increase in physicians' fees continues to trail the overall rate of inflation, according to the Consumer

Price Index. In August the physicians' services index rose by 0.5%, while the all-items component rose 0.6%. Hospital room charges rose by 1.4% and overall medical care index was up 0.6%. Over a 12-month period, the physicians' services index rose 10.4%; all items, 12.8%; and all services, 14.7%.

Charity Hospitals Under Study

Jackson, MS - Continuing investigation of the state's charity hospital program is underway.

A special House of Representatives committee will apparently consider a role for the University Medical Center in staffing the hospitals. MSMA advocates that charity hospitals be brought up to medical standards or closed. Following an MSMA study several years ago, the association recommended a charity hospital system involving UMC.

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Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

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DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole

HOW SUPPLIED

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Bottles of 500 Tablets

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RU-TUSS[®] EXPECTORANT

DESCRIPTION

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Codeine Phosphate	65.8 mg
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Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
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Alcohol	5%

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions

DOSAGE AND ADMINISTRATION Adults 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period

Children 6 to 12 years of age ½ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age ¼ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age. Use as directed by a physician

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* Mean cure rate of VERMOX[®] in treating whipworm; cure rate range of 61-75%. Data on file at Janssen Pharmaceutica Inc.

** Mean egg reduction of VERMOX[®] in treating whipworm; egg reduction range of 70-99%. Data on file at Janssen Pharmaceutica Inc.

† Rollo, I.M.: Drugs used in the chemotherapy of helminthiasis, in Goodman, L.S.; and Gilman, A. (eds.): *The Pharmacological Basis of Therapeutics*, ed. 5. New York, Macmillan, 1975, p. 1034.

†† Miller, M.J.; Krupp, I.M.; Little, M.D.; Santos, C.: Mebendazole an effective anthelmintic for trichuriasis and enterobiasis. *JAMA* 230 (10): 1412-1414, Dec. 9, 1974.

1. Registered trademark of Merck Sharp and Dohme.
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Lame Duck Congress Returns

The Congress will be returning to Washington after the November 4 elections for the first lame duck session since 1974. Eager to avoid votes on controversial issues so late in a campaign year, the leadership and Democratic members refused to consider the second concurrent budget resolution and a Republican supported tax cut for this year and recessed in September.

When Congress returns, it will deal with the work that it was supposed to complete during September, the most important of which is passage of the fiscal year 1981 budget. Of the 13 major appropriations bills necessary to operate the federal government, the House has passed 12, the Senate four and only three have been cleared for the President. While the Senate has been working hard on the second concurrent budget resolution, the House Budget Committee has yet to report its version.

Most of the major issues affecting health have been passed by both Houses and now await conference — Health Professions Education [HR 7023], NIH Reauthorization [S 988] and Budget Reconciliation [HR 7765]. The exceptions are CHAP (which has not yet passed the Senate) and Mental Health Systems, which was signed by the President in October.

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ORIGINAL PAPERS

Management of Thoracic Duct Fistula Following Insertion of Cardiovascular Prosthesis

MICHAEL D. MAPLES, M.D., * MARTIN H. McMULLAN, M.D. and
THOMAS L. KILGORE, JR., M.D.

Jackson, Mississippi

THORACIC DUCT FISTULA, an infrequent complication of thoracic surgery, occurs even less commonly after cardiovascular surgery. The incidence of chylothorax is reported in the range of 0.2% to 0.5% following thoracic procedures.^{1, 2} Thyroidectomy, subclavian vein catheterization, sympathetic nerve surgery, esophageal surgery, pulmonary resection, diaphragmatic surgery, repair of hiatus hernia, ligation of ductus arteriosus, thoracic aorta surgery, and costovertebral surgery have all been incriminated in the production of this malady. However, there have been very few cases of thoracic duct fistula following cardiac valve replacement or aortocoronary bypass.^{1, 3} Injuries to the thoracic duct may occur secondary to nonsurgical traumatic injury as well, such as penetrating thoracic injury and hyperextension injury.⁴

Lymph and chyle are conducted from the lower extremities and the abdomen by the thoracic duct to the left subclavian or external jugular vein. The course most commonly taken by the thoracic duct is that of entering the chest through the aortic hiatus of the diaphragm. It lies on the bodies of the thoracic vertebra immediately to the right of the midline and ascends in this position to the level of T-5 or T-6. At this point, it usually crosses the midline but remains immediately anterior to the vertebral bodies. The

duct continues cephalad, passes anterior to the left subclavian artery and joins the left subclavian vein near its junction with the left external jugular vein. Variable routes of the duct are frequent and numerous tributaries may be present especially in the area above T-5 and T-6.^{2, 5, 6}

A thoracic duct fistula may result in massive losses of chyle and its constituents. In an adult, the amount of chyle produced emptying into the venous system in one day may be between 1500 and 2400 ml.⁷ In addition to the chylomicrons (composed of triglycerides, cholesterol, and phospholipids), concentrations of electrolytes, protein, lipid, and glucose in chyle may approach those in plasma.⁸ This complex composition results in a challenging problem in management.

There are basically two approaches to the treatment of a thoracic duct fistula — conservative management and operative management. The most accepted conservative management includes chest tube drainage into a closed system, cessation of oral intake, intravenous hyperalimentation, and replacement of fluid and electrolyte losses. Medium chain triglycerides may be given orally to maintain caloric intake without significant increase in the chylous drainage.^{9, 10} The surgical approach to treatment involves identifying the point of leak and ligating it or ligating the thoracic duct soon after it passes through the diaphragm usually through the right chest approach.^{11, 12}

There is general agreement within the current

From the Department of Surgery, Mississippi Baptist Medical Center, Jackson, MS.

* Resident in Surgery, Vanderbilt University, Nashville, TN.

literature that a conservative approach should be tried initially. If closure of the fistula is not accomplished in two or three weeks, surgical intervention is indicated. We present two cases of thoracic duct fistula, one of which is the rare case of thoracic duct fistula following valvular or coronary artery surgery.

Case 1

H. S., a 73-year-old male, was well and working as a farmer until approximately one month prior to admission when he noted the acute onset of epigastric pain radiating into his chest. There was simultaneous pain involving both legs. There was no history of angina, myocardial infarction, or claudication. The epigastric pain radiating into the chest recurred intermittently over the next few weeks, and the patient was referred for evaluation. Physical examination was unremarkable except there were no pulses distal to a good right femoral pulse. His blood pressure was normal, and the EKG showed only nonspecific changes. Chest x-ray was suggestive of a Type III dissecting aneurysm, and subsequent arteriograms confirmed this diagnosis.

The patient experienced additional episodes of pain in spite of a normal blood pressure. For this reason he underwent resection of the descending aorta with dacron graft replacement utilizing femorofemoral bypass. Postoperatively he had respiratory difficulty which eventually necessitated tracheostomy. By the tenth postoperative day, fluid accumulation in the right chest had progressed to the point of requiring thoracentesis, and 1900 cc of serosanguineous fluid was aspirated. Three days later, the fluid had reaccumulated. A chest tube was inserted, and the fluid then had the milky appearance of chyle.

Oral nutrition was stopped, fluid and electrolytes were replaced intravenously, and hyperalimentation was instituted via a right subclavian vein catheter. Drainage from the right chest continued at a rate of 1200 to 1500 cc per day. Because of the patient's severe respiratory insufficiency, conservative measures were continued. On the 30th postoperative day, the patient experienced an abrupt temperature elevation to 104.2 F. Staphcillin and gentamicin were begun after blood cultures were taken. All catheters were discontinued and cultured. His BUN began rising, and gentamicin was discontinued. *Candida albicans* was identified in the blood culture. By the 33rd postoperative day the chest tube drainage had stopped and the right chest tube was removed. With the rising BUN and the belief that the

site of infection was removed, the candidemia was not treated with amphotericin initially. However, recurrent temperature elevations and candidemia necessitated specific antifungal treatment. Amphotericin-B was instituted but because of progressive azotemia was discontinued. Flucytosine was then utilized in an effort to suppress the candidemia which almost certainly was originating in the dacron graft. The patient's hospital course continued to be a stormy one for the next month. Respiratory distress, fungal and bacterial infection, and azotemia plagued his hospital stay intermittently. Three months following surgery, he was discharged from the hospital with a tracheostomy and feeding tube in place and in mild renal compromise (BUN 41). Flucytosine was continued. Blood cultures had been negative for two weeks prior to discharge. He subsequently died at home three months later, presumably of candida infection in the graft and its complications. No autopsy was obtained.

Case 2

B. D., a 62-year-old female, underwent saphenous vein bypass grafting to the left anterior descending coronary artery in March 1977. Four months earlier she had experienced an acute myocardial infarction. In addition to the 90% proximal stenosis of the left anterior descending, she had been shown to have a totally occluded posterior descending coronary artery arising from the right coronary. There was moderate inferior wall akinesis but with no evidence of mitral regurgitation.

In April 1977, she presented to the emergency room in acute, severe congestive heart failure. Cardiac catheterization shortly after admission strongly suggested the presence of cardiac tamponade. She was taken immediately to surgery, and 300 cc of serosanguineous material was removed through a secondary median sternotomy incision. Her immediate postoperative course was characterized by extreme low cardiac output requiring dopamine and nitroprusside for support. She eventually stabilized and was found to have a significant apical systolic murmur radiating to the axilla. Three days later she underwent repeat cardiac catheterization which revealed the left anterior descending saphenous vein graft to remain patent. She was found, however, to have severe mitral regurgitation presumed to be on the basis of papillary muscle rupture or dysfunction. The same day she underwent mitral valve replacement utilizing a Bjork-Shiley prosthesis. She tolerated this procedure well and had a surprisingly uneventful immediate postoperative course. Within



Figure 1. Patient B. D., Case 2. Lymphangiogram demonstrates the superior and anterior accumulation of chylous material.

three days after surgery, she did not require pharmacologic support and was discharged from the intensive care unit. She was noted on routine chest x-ray to have small bilateral pleural effusions during this period.

On the seventh postoperative day she was severely dyspneic and tachypneic. Chest x-ray showed a large left pleural effusion. Thoracentesis removed approximately 2000 cc of milky white fluid, characteristic of chyle. A chest tube was inserted with immediate improvement. During the next two weeks chest tube drainage continued in the range of 700 to 1200 cc per day. In the management of this problem, intravenous hyperalimentation was precluded because of the prosthetic valve. The patient's appetite and general well-being slowly declined during this two week period.

With no change in the amount of drainage from the thoracic duct fistula and the slow demise of the patient being imminent, a surgical approach was decided upon. Lymphangiogram showed the leak to be in the left upper chest anteriorly (see Figure 1).

Approximately 1½ hours prior to surgery, 0.5 cc of #1 Blue Dye was injected into the dorsum of each foot in hopes of visualizing the thoracic duct more easily at the time of surgery. Upon entering the left chest in the fifth intercostal space, the fistula was not readily visible nor was there any Blue Dye. The descending aorta was retracted medially to expose the vertebral bodies and the thoracic duct still could not be identified. Methylene Blue Dye was then injected into the stomach by a nasogastric tube and visualization of the duct was accomplished. Ligatures were placed around the duct in the mid-thoracic area. Attempts at visualizing the primary leak in the upper anterior chest were unsuccessful.

Postoperatively there was no recurrence of the effusion, and the patient slowly recovered. She subsequently has been able to return to normal activity.

Comment

Management of a thoracic duct fistula can be an extremely difficult problem. In the presence of a

prosthetic device these problems are intensified. We believe that because of the infrequency of thoracic duct fistulae, especially in association with a prosthetic device, no one has sufficient experience with its management to be dogmatic in proposing an approach to treatment. It would appear, as a result of the fatal outcome of Case 1, a conservative approach utilizing hyperalimentation is not justified. On the other hand, the successful result of Case 2 tends to support the more aggressive surgical approach.

Several points are to be made regarding the surgical approach. If the chylus accumulation is in the left chest, the injury to the duct is usually above the fifth or sixth thoracic vertebra. It should be strongly emphasized that the thoracic duct is an evasive structure and its route is highly variable. Attempts at its identification can be frustrating and/or fruitless.

Lymphangiography performed prior to surgery will aid in locating the site of injury and assist one in determining the surgical approach. In Case 2, we chose a left thoracotomy because of the possibility of two attack points: (1) the main thoracic duct in the mid- to lower-chest and (2) the point of primary leak with the potential to oversee it directly. The exposure through a left thoracotomy is hampered by the position of the thoracic aorta, but in the mid-chest it can be mobilized by ligating and dividing intercostals and retracting the aorta either medially or laterally to gain satisfactory access to the thoracic duct. The right chest approach is used for right-sided effusions, since exposure can usually be gained without difficulty as the thoracic duct passes into the chest through the aortic hiatus.

Numerous dyes have been used to try to visualize the thoracic duct at the time of surgery. In Case 2, we initially attempted the subcutaneous injection of #1 Blue Dye intradermally and subcutaneously into the dorsum of both feet. At 1½ hours post-injection, no dye was visualized in the lymphatic system during the course of the operation. Results are variable, but the instillation of Methylene Blue Dye into the sto-

mach by a nasogastric tube at the time of surgery seems to work as well as any method and was successful in this case.

Summary

Thoracic duct fistula is an infrequent complication of thoracic surgery and is a challenging problem in management. In certain instances, especially persons with valvular prostheses, early operative treatment may be indicated. The complications of both surgical and non-surgical approaches must be carefully considered when deciding on a therapeutic course. ★★★

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Colon Obstruction Secondary to Adhesive Splenomegaly: A Case Report

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Jackson, Mississippi

EMERGENT OPERATION FOR SPLENIC RUPTURE is well known to all general surgeons. Splenomegaly without rupture, however, is rarely associated with conditions requiring immediate surgical intervention. We present a case of acute obstruction of the sigmoid colon secondary to adhesive splenomegaly which required emergency laparotomy and splenectomy for relief of the obstruction.

Case Report

A 64-year-old black male was admitted to the University Medical Center Ophthalmology Service for evaluation of a corneal ulcer. His admission workup demonstrated significant congestive heart failure, a white blood count of 29,400 and a platelet count of 15,500.

Because of his cardiac and hematologic manifestations he was transferred to the Medical Service where further assessment demonstrated the following: (1) an absolute lymphocytosis compatible with chronic lymphocytic leukemia, (2) congestive heart failure, mostly right-sided, secondary to severe chronic obstructive lung disease, (3) remote, inactive tuberculosis, (4) abdominal distention and (5) splenomegaly. Appropriate management was instituted for these problems. On the fourth hospital day, the patient experienced a grand mal seizure, his first ever. A spinal tap was normal and EEG demonstrated multiple seizure foci.

His abdominal distention progressed, and he became obstipated. The Surgical Service was consulted on the fifth hospital day. Evaluation at that time demonstrated a thin black male in significant respiratory distress. He was afebrile but significantly tachycardic. The abdomen was markedly distended, moderately tender and quite tympanitic. Bowel

sounds were active. A large mass was readily palpable in the left upper quadrant of the abdomen, and it extended toward the umbilicus. There was evidence of previous bilateral herniorrhaphy without recurrence. Rectal examination was normal and the stool was guaiac negative. Lab data revealed a hematocrit of 19.3%, a hemoglobin of 6.7 gms%, a white cell count of $72,000/\text{mm}^3$ with 1% monos, 2% bands, 2% blasts, 21% segs and 74% lymphocytes.



Figure 1. Abdominal film demonstrating mass effect in left upper quadrant and virtual absence of rectal gas.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

Extensive interstitial and pleural disease was present on chest x-ray. Flat and erect abdominal films (See Figure 1) demonstrated a large mass effect projecting from the left upper quadrant. The gas pattern within the abdomen was suggestive of partial small bowel obstruction. Colon gas was visible from the right colon to the splenic flexure (i.e. the region of the mass effect). There was a relative absence of gas in the sigmoid colon.

Because of the patient's multiple medical problems, his intestinal obstruction was managed with a 24-hour trial of Miller-Abbott tube decompression while his pulmonary status and cardiovascular status were optimized. He was then taken to surgery for operative relief of the obstruction.

Through a midline incision, the massively enlarged spleen was exposed. Although not markedly dilated, the left colon was found to be tightly stretched over the anterior surface of the spleen with the posterior colon wall being adhered to the splenic tip at the site of a previous subcapsular hematoma (See Figure 2). Colon gas could be milked to this point but no further because of the acute angulation of the colon over the splenic tip.

The attachments of the colon were taken down and the spleen removed with minimal difficulty by standard techniques (See Figure 3). Colon gas could then be easily milked into the rectum (See Figure 4).

It should be stressed that the adhesion alone was not the obstructing lesion, but allowed the colon to be carried medially, angulated acutely over the spleen and thus obstructed.

Discussion

The common causes of colon obstruction are well known and have been repeatedly reviewed. Cancer, volvulus and diverticulitis account for the vast majority of colon obstructions encountered in clinical practice. In Becker's review of 205 cases of acute obstruction of the colon, cancer and volvulus were responsible for 72%.¹ This is consistent with the findings of Byrne in his analysis of 197 cases.² In his series 65% of obstructions were due to malignant neoplasm, with volvulus being the second most common obstructing lesion with 11% of the total. The University of Mississippi Medical Center experience, reviewed by Barnett,³ has been similar.

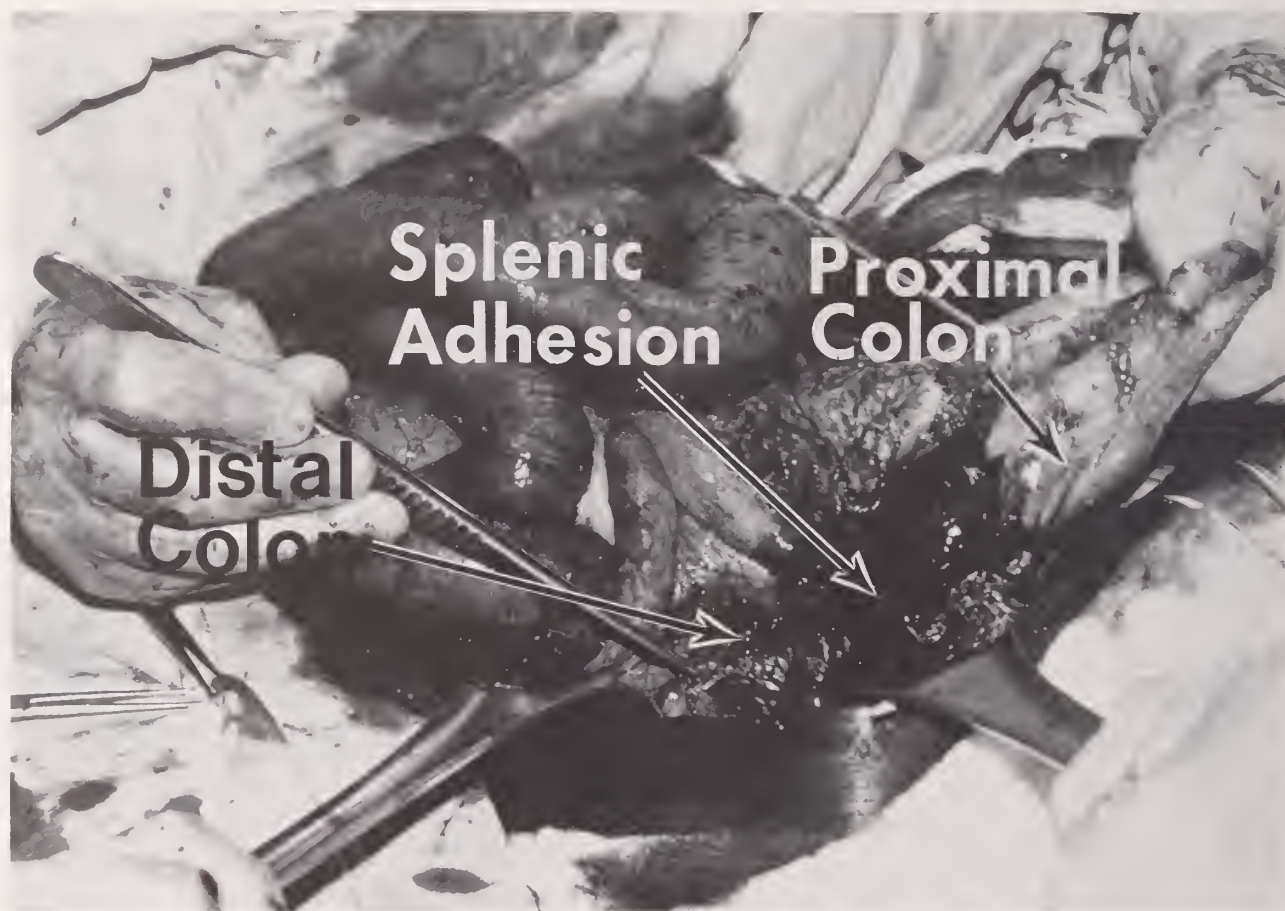


Figure 2. Descending colon angulated over splenic surface.



Figure 3. Massively enlarged spleen.



Figure 4. Following splenectomy, gas easily passes point of obstruction.

Adhesions are a far less common etiology of colonic obstruction, accounting for 2.4% of the cases reviewed. Extrinsic pressure is also an uncommon mechanism of colonic obstruction. Becker ascribed only 3.4% of his cases to extraluminal pressure with pelvic carcinomatosis and abscess being responsible for all cases. Wangenstein, in his monograph on intestinal obstruction, described only 56 cases in his vast experience of obstruction secondary to extraluminal compression. Virtually all were due to neoplastic lesions.

Splenic pathology is a rare cause of intestinal obstruction. The so-called "wandering spleen" may be found in the pelvis, and because of compression of the small bowel by the pedicle of the spleen, may produce obstruction.⁵ The spleen may produce intestinal obstruction by another mechanism. Following traumatic rupture of the spleen, splenic fragments may become seeded within the peritoneal cavity. As these fragments enlarge, they may angulate the intestine and manifest as intestinal obstruction.

Splenomegaly *per se* is not described in the major English literature as a cause of intestinal obstruction.

Goldstone,⁶ in reviewing 300 splenectomies, found 34 cases performed for "massive splenomegaly" (i.e. ≥ 1500 gms). All 34 patients were symptomatic, complaining most often of abdominal fullness (82%). Early satiety due to gastric compression was noted in four of these patients. No cases of colon obstruction, either partial or complete, were noted.

This case represents an unusual case of large bowel obstruction secondary to a unique combination of pathophysiologic processes. ★★★

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Radiologic Seminar CCVIII: Superior Mesenteric Artery Syndrome: A Case Report

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OF THE MANY KNOWN CAUSES of duodenal obstruction, one of the more controversial ones is the superior mesenteric artery syndrome. Since first described by Rokitsky in 1849,¹ this entity has been referred to as Wilkie's syndrome, duodenal stasis, arteriomesenteric duodenal compression, vascular compression of the duodenum, cast syndrome, and chronic duodenal ileus.^{2, 3} The purpose of this case report is to encourage the inclusion of this entity in the differential diagnosis of duodenal obstruction, as well as to review the most common clinical and radiographic manifestations.

Case Report

S.G., a 12-year-old female, was admitted to the University of Mississippi Medical Center for evaluation of possible gastric outlet obstruction. A two-week history of nausea, vomiting, and diarrhea associated with a pneumonia preceded her referral, which was prompted by a poor response of her gastrointestinal symptoms to conservative measures even though the pneumonia resolved. An upper gastrointestinal series performed at another hospital the morning prior to her admission to UMC revealed only gastric distention. Physical examination here revealed a tall, extremely thin female with only mild abdominal tenderness and no peritoneal signs. A nasogastric tube was inserted and bile-stained gastric contents mixed with residual barium were aspirated in significant volume. Another upper gastrointestinal examination was then performed via the NG tube and revealed a massively distended stomach, normal pylorus, and a dilated duodenum down to the junction of its third and fourth portions where a vertical, linear obstruction to the flow of barium occurred (see Figures 1 and 1a). Peristalsis in the dilated C-loop of the duodenum revealed to-and-fro movement of the contrast. Following several days of nasogastric suc-

tioning, an attempt to delineate the relationship of the superior mesenteric vessels to the distal duodenum by computerized tomography failed due to the relative paucity of retroperitoneal fat and lack of patient cooperation. Exploratory laparotomy was performed, revealing definite compression of the distal duodenum by the superior mesenteric artery and vein. No other abnormalities were identified, and the duodenum was mobilized and moved into the right paravertebral gutter along with the proximal jejunum.

Discussion

When the embryonic gut reenters the abdomen from the umbilical stalk at about 10 weeks of gestation, it rotates in a counterclockwise direction and the superior mesenteric artery comes to lie cephalad to the third portion of the duodenum. As a result of man's erect posture, the superior mesenteric artery arises from the aorta at an acute downward angle, usually between about 20° and 60°; this aortomesenteric angle contains the left renal vein and uncinate process of the pancreas as well as the third portion of the duodenum. If the angle is less than 20°, as it is in the SMA syndrome, duodenal compression can result.⁴

The age of presentation of the SMA syndrome can be from early childhood (one reported case involved a three-week-old infant) into late adulthood; 75% of patients are between 10 and 39 years of age, and more than 60% of all patients are women.⁵ By far the most common symptom is bilious vomiting. Abdominal pain and distention are other common presenting symptoms.³ All symptoms are exacerbated after meals; therefore, these patients frequently lose weight because they quit eating. Occasionally a patient will get relief for a period of time by assuming a "knee-chest" position, and such postural relief can be of diagnostic significance.⁵

Clinically two forms of superior mesenteric artery syndrome are felt to exist. The chronic form is seen in a tall and slender or undernourished individual

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From the Department of Radiology (Pediatric Radiology Section), University Medical Center, Jackson, MS.



Figure 1



Figure 1A

Upper GI series (Figure 1) with spot film (1A). Marked gastric distention and dilated duodenal loop. Abrupt vertical line cutoff of contrast in distal duodenum.

whose body habitus predisposes to a smaller-than-normal aortomesenteric angle.⁶ In children this can occur as a result of rapid weight loss or rapid growth without weight gain; two examples of this are growing, dieting preadolescent and adolescent females and adolescent males involved in athletics.⁷ In fact, Akin et al state that no patients with vascular compression of the duodenum have been described as obese;⁵ Mindell and Holm did report one case of an immobilized obese female who developed SMA syndrome.⁸ The more acute form is usually seen in a patient without previous gastrointestinal symptoms who for some reason undergoes a prolonged period of immobilization, especially in the supine position.⁶ Examples of this type would be severely burned patients,² patients in body casts or braces for scoliosis,³ and even one young lady in her new girdle.⁷

An acute problem in either of the above forms is aspiration of gastric contents from a markedly distended stomach, which has on more than one occasion resulted in the death of the patient prior to diagnosis.^{3, 5} Another problem of more chronic nature is that of missed diagnoses, with many patients, including children, being institutionalized for "psychological disturbances" or anorexia nervosa without adequate evaluation having been performed.⁷

Plain film radiographic evaluation in these patients may reveal a "double bubble" gas pattern due to marked stasis within the stomach and duodenum. Barium contrasts studies are the diagnostic procedure of choice, preferably done after aspiration of gastric contents. The stomach is usually long, J-shaped, and dilated.⁷ Churning to-and-fro peristalsis is noted in the dilated duodenum proximal to the obstruction.² The obstruction itself is best described as an abrupt distal duodenal vertical straight line cutoff of barium as seen on the anteroposterior projection.⁶ This usually lies anterior or just to the right of the spine and can often be relieved by having the patient lie on his left side, prone, or by getting on his hands and knees.⁷ Seldom used but occasionally helpful are simultaneous barium contrast studies with selective superior mesenteric arteriograms; however, the additional expense and time requirements make any diagnostic gains costly.³ Computerized tomography could be attempted but will frequently not lend any additional information beyond the barium studies; the retroperitoneal and intra-abdominal fat which usually aid in separating soft tissue planes and structures is a major problem, as it is usually lacking in these patients. Another modality to consider would be ultrasonography for evaluation

of the aortomesenteric angle. This examination is better performed in the absence of significant interposed fatty tissue.

Therapy initially is conservative, with attempts made to increase the aortomesenteric angle by increasing the amount of retroperitoneal fat at the root of the mesentery. Multiple small high-caloric feedings with an erect or hand-knee position after eating has helped occasionally. Intravenous hyperalimentation is another means of increasing the patient's weight.⁸ The radiologist may attempt passage of a nasogastric tube under fluoroscopic control beyond the site of obstruction thus allowing feedings to progress, although this has seldom proved effective.² If the patient is in a spica cast, an anterior window may be of assistance.⁸

Surgically, several approaches to the problem are possible. Mobilization of the entire duodenum with repositioning of it and several feet of proximal jejunum into the right paravertebral gutter offers early post-operative function and low morbidity. Simple lysis of the ligament of Treitz without repositioning of the duodenum seldom proves effective.¹⁰ Duodenojejunostomies have also been performed, but carry not only a longer operating time but also greater morbidity due to an intestinal suture line. Operative

intervention is usually necessary although a course of conservative management is warranted, as medical treatment in one study resulted in recovery of only one-third of the patients.³ ★★★

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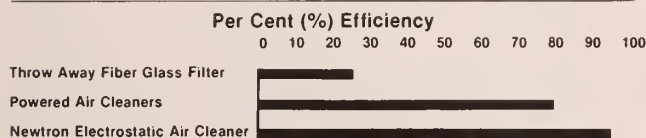
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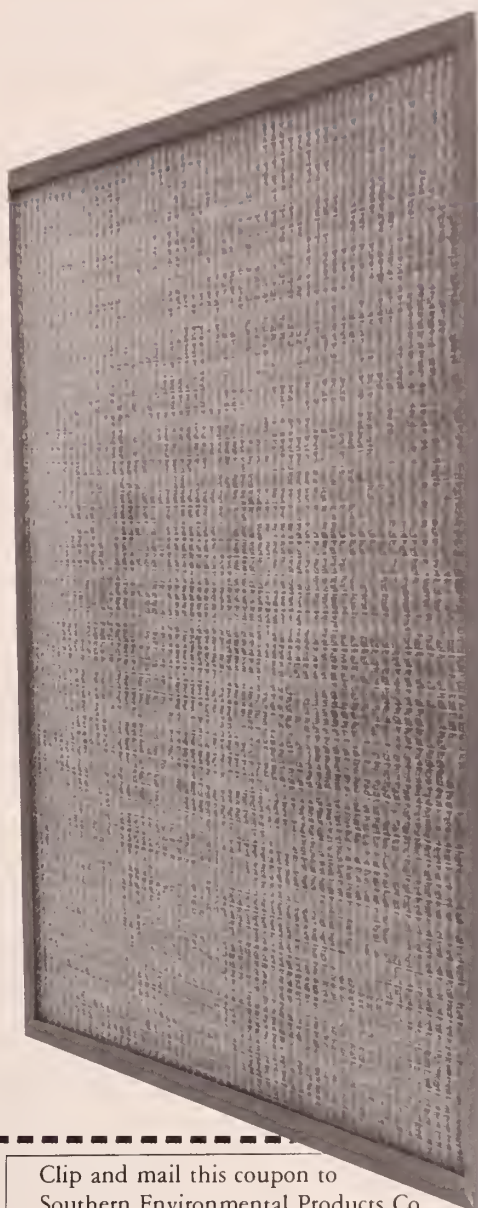
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The President Speaking

Are You Involved?

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

Before this article appears in JOURNAL MSMA we will have had our presidential election. At this point it appears that the election is too close to call. I think there is one very important point that all of us in medicine should be cognizant of. That is, regardless of which candidate is elected, medicine is in for some rough times.

This will be nothing new for medicine, for it has had trials and tribulations in the past. But through a strong organization and leaders who knew and cared what it would take to put medicine where it rightly belonged, it has survived and prospered to a point that is almost unbelievable.

The AMA is putting on a concerted effort this year to increase its membership. We need and must have a substantial increase to have the finances that are necessary to carry on the programs which are desired.

As we increase the number of physicians, we must also increase our total membership. By the year 1985 there will be one doctor for every 500 people. An interesting fact is that a larger percentage of the new docs will be women and foreign medical graduates. We find that in these two groups, only 18% of the women and 28% of the FMGs belong to the AMA. This is a fertile field that we must cultivate.

There are two ways in organized medicine that we can make ourselves heard and respected. Of course, the first and most important is to make medicine good and affordable. We have made it very good with our scientific and technical knowledge. At the present, I think we can say it is affordable, but how much more can it stand? The second way that we can and must be heard is through unity. Unity gives us strength; medicine is its own worst enemy. We must work and pull together to see that medicine not only gets better, but that it is available to all people at a cost that is affordable. I do not think that medicine is a social right because there are too many people who abuse their bodies selfishly, and therefore I see no need for their expense to be put upon the general taxpayer.

There are those of us who in the past have said that the MSMA and the AMA did not express or present our views. In general in the years past, this may have been true. I doubt it. Medicine is so large and there are so many different views; in fact, there are about as many views as there are doctors. I do believe at the present time our organization reflects the majority of the important views and issues of medicine. The MSMA and AMA Houses of Delegates are composed of those persons whom you have chosen. Maybe your input is not what it should be. Why not join and let your views and thoughts be known? It has been said not to "hide your light under a bushel." Let our light shine by becoming a member or talking someone else into a membership.

Your membership dues statement will be arriving shortly. Let us see that we get these in promptly; and by the way, be sure to pay your wife's Auxiliary dues. We need these ladies to help us spread the good work and words.

It's Your Responsibility

As we approach the time of annual billing for MSMA dues, it is appropriate that every physician be reminded of his responsibility to the profession as it relates to politics.

Almost every other profession or group has a Political Action Committee, and many of these support candidates who are in direct opposition to organized medicine's viewpoint.

Isn't it time physicians took on their responsibility to prevent the erosion of the practice of medicine? This year, join AMPAC and MPAC; and give generously. It's your responsibility. — B.C.M.

Usual, Customary and Reasonable Fees

(Ed. Note: Dr. J. William Wright, Jr., president of The American Council of Otolaryngology, published the following statements in the Council's July 1980 "Newsletter." This is such a succinct discussion of a current problem that permission was requested to reprint it in JOURNAL MSMA. Dr. Wright kindly granted this permission. — M.W.L.)

For the most part, both patients and physicians are happy that the patient has had the foresight to obtain insurance to help pay medical bills. Physicians know, and patients in increasing numbers are discovering, that this coverage can vary tremendously.

It is unfortunate that the completeness and value of this coverage has been exaggerated to the insured by third party payers, both governmental and private. Far too frequently the policy holder has been allowed or even led to believe that his insurance plan covers all contingencies. There has been little enthusiasm or effort on the part of third party payers to educate the insured as to the deficiencies of his policy. This lack of enlightenment extends past the period of the sale of the policy and extends into the reimbursement stage.

On settling a claim, the third party payer more and more frequently is notifying the insured, who is complaining about partial reimbursement for

medical bills, that "your physician has overcharged you." In our observation, this statement is most frequently heard when the patient holds a "usual, customary and reasonable" policy.

By common English language usage, the patient holding such a policy has every right to believe that he will be fully covered unless the physician's charge is indeed not his "usual and customary" charge for similar services.

In the beginning, "usual and customary" was interpreted as the customary charge which a physician usually made to all of his patients for a given procedure. For many perfectly valid reasons, these charges might vary considerably from one location to another and from one physician to another for essentially the same given condition.

Very quickly third party payers in an attempt to establish conformity and cost containment procedures began to erode the historic meaning of "usual" and "customary." They established a new dictionary of the English language and corrupted and adulterated the meanings of "usual" and "customary" to say that they meant the usual and customary average of all physician's fees for a certain region and a given procedure. As a further limitation to paying any given physician's usual and customary fee, they have in many instances elected to pay an arbitrarily established percentile of the average of all fees. They have also included the term "reasonable" which implies that even the usual and customary percentile average could be further limited by their decision that such a fee was in fact "unreasonable."

By the utilization of such machinations, the patient now holds a policy which is only dimly related to what he thought he had, namely a policy which would reimburse him for the usual and customary charges of a reputable physician in the community.

As a further economy measure, many third party payers have determined that they will review their version of "usual, customary and reasonable" fees only every six months, once a year or in some cases only every 18 months or longer. Thus current payment by insurers under "usual, customary and reasonable" policies reflects not current charges by

the physician, but an outdated, arbitrarily selected percent of the composite fees of a region.

Some physicians must accept a part of the blame for everyone being unable to ever actually receive his usual and customary fee for a given procedure. This has come about when they have agreed to treat a patient in financial straits for a fee less than their usual and customary charge and have agreed to accept "insurance only." Knowing that they were not going to charge the patient anything more than his insurance would cover and being aware of what the insurance company might pay, they have filed the insurance claim indicating not their usual and customary fee, but a lesser amount which they were aware was compatible with the insurance company's schedule. Instantly this lowered fee enters their profile and in the future there is no way that the insurance company's statistics will indicate what their or anyone else's usual and customary fee is.

I have observed no significant effort on the part of third party payers to educate their policy holders as to the method by which they arrive at usual,

customary and reasonable reimbursement. On the contrary, there has been a great willingness to inform the insured that the answer to his problem is that his physician has overcharged him.

All that the insurance agency should be saying to the patient is that, "this is the maximum allowable fee payable under your particular coverage." There is no enthusiasm for using this phraseology since obviously this would require the payer to explain to the insured why he does not have what he thought he had.

Patently, the third party payer has no expertise which would legitimately permit him to state that in any given instance the physician had overcharged the patient. Since such a remark is extremely disruptive to the physician-patient relationship, we have been interested in discovering if such a remark would constitute libel and/or slander. The results of our personal investigations into this matter convince us that it might be well for any physician so accused to consult his attorney as we have done concerning possible legal action against the makers of such a statement.

Apparently others are interested in the ill effects flowing from such statements. Most recently the Tennessee Medical Society proposed a resolution to the Reference Committee A of the American Medical Association which suggests that insurers be required to inform the patient that their reimbursement is "the maximal allowable fee payable under your coverage." The House of Delegates passed a substitute resolution 6-A, "be it resolved that the AMA be requested to aggressively pursue with the insurance industry the improvement of terminology in third party communications, so that the term 'reasonable charge' will not be misleading to the public and report its progress in this area at the 1980 interim meeting." It would seem most appropriate that those concerned with this issue make their feelings known to the American Medical Association so that hopefully these negotiations with the insurance industry and third party payers would be productive of a ban on the use of the phrase "your physician has overcharged you."

In conclusion let me stress that there is much merit in a system of reimbursement based upon a physician's "usual and customary" fees. What is objectionable is the practice of selling the recipient a policy containing this phraseology when in fact the benefits actually paid are determined by an entirely unrelated method. Even more objectionable is the concealment of this deficiency by stating, "your physician has overcharged you."

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"Enclosed is a check which I'm paying under protest. The reason I have not paid the statement earlier is that I am considering a malpractice suit against you."

The above statement was the introduction to a letter which precipitated the filing of an incident report to a malpractice insurance company. The letter continued. . . .

"Within one-half hour after my accident I was admitted to your clinic and was told to see Dr. _____. After waiting approximately three hours, he finally had my left large toe x-rayed and said the dislocated toe was reset and he wrapped tape around the large toe and the toe next to it and told me to come back in one week. At the end of one week, I returned and waited for him approximately three hours again. The toe was re-x-rayed. I was told . . ."

Is a three-hour wait too long for your patient to wait on you? Your waiting room can be a breeding ground for malpractice suits. Many physicians are unaware of the activities that take place in their front office and fail to recognize that a doctor-patient relationship is being formed even before the patient is seen. All too frequently, anxious people sit for long periods in waiting rooms because of ineffective scheduling.¹ Compounding this is the fact that when a patient has been kept waiting, many doctors don't even acknowledge the inconvenience to the patient.

Good management calls for making the best possible use of your time without abusing patient's time. Patients will generally wait for about 20 minutes without complaint, but after that time period elapses, they begin to be annoyed.²

It is this annoyance which creates resentment — resentment that later, coupled with a bad result from an operation or treatment gives rise to a malpractice suit against a physician.

The problem of long waits, emergencies excluded, is a result of improper scheduling, poor use of the physician's time, and inadequate office management. The most effective method for determining proper appointment scheduling is to consider the total time required to process a patient before and

after seeing the physician. The doctor should establish procedures and standards for his office and spot-check for proper patient handling.³ Obviously, there will always be interruptions, complications and emergencies, but over-scheduling should not be permitted.

How do you know how much time to allow for the procedures you do most frequently? One way to find out is to analyze your own practice (see Figure 1).

TIME SURVEY

Mon. ☐ Thurs. ☐
Tues. ☐ Fri. ☐
Wed. ☐ Sat. ☐

Doctor _____ Date ____/____/____

Appointment Type: First Exam ☐
Recheck Visit ☐
Acute Illness, Injury ☐
Other ☐
Specify _____

Times (Record to nearest minute)

A. Appointment Time _____A.M. _____P.M.
B. Patient enters exam room _____A.M. _____P.M.
C. M.D. enters exam room _____A.M. _____P.M.
D. M.D. leaves exam room _____A.M. _____P.M.
E. Counseling time _____A.M. _____P.M.
F. Patient leaves office _____A.M. _____P.M.

Figure 1. Example of a time survey form which might be useful in determining how long your patients are waiting.

From this patient flow record you will be able to determine approximately how long it takes you for first visits, follow-up visits, and the various procedures you frequently perform. You will also find out if your appointment system is working. If patients are waiting long periods in the reception or examination room, maybe you should schedule appointments further apart or devise another way to speed up traffic flow.⁴

Since excessive waiting time is a major cause of patient dissatisfaction, it should be high on your list of problems to remedy, or at least attempt to improve in your practice.

References

1. Malpractice Digest, July/August, 1977.
2. "The Business Side of Medical Practice," American Medical Association, 1979.
3. Malpractice Digest, loc. cit.
4. "The Business Side of Medical Practice," American Medical Association, loc. cit.

From the September, 1980 issue of *State Volunteer Mutual Insurance Company News*, a publication of Tennessee's captive professional liability company. Reprinted with permission.

MEDICAL ORGANIZATION

Central Medical Society Hears Former HMO Medical Director

"Learn from the mistakes we made . . . history does not have to repeat itself."

That was the admonishment recently issued to Central Medical Society members by Dr. Kenneth J. Olds, former medical director of the now defunct ChoiceCare, as he described the failure of one of the nation's leading examples of an Individual Practice Association-Health Maintenance Organization (IPA-HMO).

Physicians participate in an IPA/HMO on an individual fee-for-service basis in contrast to the staff model, closed panel HMO where they are salaried employees.

In most IPA arrangements, the physician agrees to assume some financial risk for delivering medical services. He does this by accepting a percentage of his regular fee (usually 85-90%). At year end, if utilization has been within projections, the physician may receive the balance of up to 100% of his claims. He may also share in any surplus realized for other services such as hospital and prescription services.

Dr. Olds credited his initial belief that the HMO approach would minimize cost increases in medical care as a reason for his involvement with the Colorado IPA/HMO. At the time, he believed that putting physicians at risk for a portion of the cost would

create a certain awareness among physicians that might help contain rising costs, and he also believed that the local peer review required by an HMO would be a faster, fairer way of resolving problems facing patients and doctors in the area.

His experience with ChoiceCare causes him to reject those arguments, and he now believes not only that HMOs have very little redeeming value for physicians, but also that patients "will eventually recognize them as second class health care."

The primary fault in the HMO concept is that it appeals largely to high risk patients and high utilizers, Dr. Olds observed. Compound this natural selection process with management's sometimes indiscriminate marketing, and the result is that physicians are pressured to ration care.

Doctors are uncomfortable with a situation that forces them to consider their patients' needs in terms of the HMO budget, he said. As pressures mounted for the ChoiceCare physicians to reduce hospital utilization, so did the belief that the quality of health care would be compromised. ChoiceCare physicians began to be drawn into disputes over contracts which created unreasonable demands on them and potentially dangerous effects on their patients, he said.

Patients should certainly be uncomfortable with a situation that tells the doctor, "the less you do for your patients, the more money you will make."

But are they uncomfortable? Dr. Olds noted that surveys continue to show that HMO subscribers are satisfied with their plans, and he admits that in his area they would sign up again "in droves." After all, ChoiceCare subscribers "abused the system mercilessly" and received \$1.2 million worth of health care they did not pay for, Dr. Olds commented.

Responding to a question, Dr. Olds said physicians should not be afraid to compete with a closed panel HMO. In spite of the government's emphasis on getting labor and industry support for HMOs, only a small percentage of major company employees are accepting the HMO option, he explained.

Of the 250 existing HMOs in the country, only seven are financially sound, Dr. Olds declared. He expressed doubt that the basic flaws in the HMO concept will ever be resolved to a degree that will make them an effective mechanism for reducing health care costs while providing quality health care.



Dr. Kenneth J. Olds of Greeley, CO, spoke on the formation and management of HMOs/IPAs during a recent meeting of Central Medical Society. Dr. Olds, second from left, is former medical director of ChoiceCare. Society officers with Dr. Olds are, from left, Dr. Myron W. Lockey, program chairman; Dr. Fred McMillan, president; and Dr. Mart McMullan, secretary-treasurer.

UMC Authorized to Seek CON Approval for Perinatal Center

A new state perinatal health care center came a step closer to realization recently when the Board of Trustees of Institutions of Higher Learning authorized the University Medical Center to seek certificate of need approval for construction of the new building. The building and equipment are estimated to cost \$20-25 million.

The proposed new facility would serve as the tertiary center of a statewide maternal/infant care system. Mississippi leads the nation in maternal and infant mortality.

The regionalization project has the endorsement of a number of organizations in the state, including MSMA. The association's Perinatal Advisory Committee formulated guidelines for the project which were approved in 1979.

Under the regionalization system the University Medical Center's perinatal unit will have an expanded role in rendering patient care to normal and high risk patients, research in new and sophisticated areas of perinatal medicine, risk assessment, data assimilation and analysis, and education of both future and existing health care providers.

The existing perinatal facility at UMC, designed for 2,200 deliveries per year, accommodated nearly twice that number in 1979. Projections indicate that the unit may serve over 5,000 in the near future.

Medicaid Seeks \$50 Million Increase

The Mississippi Medicaid Commission will seek a \$289,896,926 appropriation from the 1981 Regular Session of the Mississippi Legislature to fund its fiscal year 1982 program.

The funding request represents a \$50 million increase over funding for the current year and will require a \$69.2 million state appropriation to match federal funds totaling some \$220 million. This year's state appropriation for the Medicaid program totaled \$58.5 million.

Medicaid failed to receive the full state appropriation requested for this year, necessitating a cutback in some services including a limit of 12 annual physician visits. Current expenditures, particularly in the areas of hospital, physician and drug claims, are exceeding budget expectations. If this trend continues, Medicaid will either have to obtain a deficit appropriation from the 1981 Legislature or cut services further.

At a recent meeting the Physicians' Technical

Advisory Committee to Medicaid went on record to urge all Mississippi physicians to seek their local legislators' support for necessary funds to support the Mississippi Medicaid program.

GMENAC Report: Physician Surplus Predicted

The Graduate Medical Education National Advisory Committee (GMENAC) has completed a four year, \$4 million study of trends in health professions requirements and presented its findings to the Secretary of HHS, Patricia Harris.

At the heart of the 21-member (13 physicians) committee report is the finding that there will be 60,000 excess physicians in 1990; 130,000 excess physicians in 2000; and surpluses of physicians in 19 medical specialties.

Among the more than 100 recommendations made by GMENAC were:

- * A reduction of 10 percent (from 1978 levels) of first year students in medical schools;
- * Severe restrictions on the entry into practice of foreign trained physicians;
- * Incentives to encourage residents to enter into shortage specialties;
- * Reductions in residency positions in oversupplied specialties;
- * Holding the number of physician assistants and nurse-midwives in training to current levels.

In her acceptance comments on the report Secretary Harris stated, "Under the leadership of Dr. Alvin R. Tarlov of the University of Chicago, the panel has made a series of recommendations that will become part of the debate about the public policy that will determine the training and distribution of physicians for the next two decades."

Meanwhile, AMA Executive Vice President James H. Sammons, M.D., urged caution for those who will be reviewing the report. "Because of the methodology used, it is necessary to view the report and the recommendations of the GMENAC Committee with caution before they are applied to the American health care system. We must keep in mind that while the GMENAC findings may provide an interesting assessment of manpower projections and supply today, history has shown that long-term medical manpower projections are extremely difficult to make, given changing economic trends, technological innovations, a mobile population and a rising demand for services."

GMENAC's charter has now expired but a provision in health manpower legislation (HR 7203) would provide statutory authority to continue the GMENAC activity.



The 25th annual Mississippi Thoracic Society meeting and combined Dr. Henry Boswell Lecture was held recently in Jackson. Mississippi physicians elected to serve as officers and recognized for outstanding service in programs of MTS, medical section of the Mississippi Lung Association, are (from left) Dr. A. Jerald Jackson of Hattiesburg, MTS secretary-treasurer; Dr. John D. Morgan of McComb, newly elected president; Dr. Joe R. Norman, Christmas Seal Professor of Respiratory Disease, UMC; Dr. Dwight S. Keady, outgoing president and Dr. Robert P. Henderson, vice-president, all of Jackson. The lecture series provides postgraduate education for physicians in pulmonary medicine.

PHYSICIANS

One of America's largest health care corporations is currently seeking a part-time Physician for our Plasma Donor Center located in Mississippi. Responsibilities will include performing physicals in conjunction with donor screening and evaluation. This part-time position would provide support when regular staff physicians are on vacation.

Our requirements are flexible and we will consider licensed but non-practicing Physicians as well as those desiring to work on a consulting basis.

We offer excellent working environment and a highly competitive salary. For further information please send curriculum vitae to:

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Dr. Pankratz, Noted Medical Education Leader, Dies

Dr. David S. Pankratz, one of the primary influences in expanding Mississippi medical education and establishing the University of Mississippi Medical Center in Jackson, died October 6 at Oxford-Lafayette County Hospital. He was 81.

Dr. Pankratz, born on the Cheyenne-Arapaho Indian Reservation near Cordell, OK, came to the University in 1939 as a professor in the two-year medical program. He was named its dean in 1946 and is credited with working with citizens, leaders and members of the state legislature in gaining approval and appropriations for the four-year school, which opened its doors in 1955 in Jackson. Under his leadership, the school earned accreditation, funds were appropriated for a research wing, and the school graduated four classes of doctors, the first ever trained entirely in Mississippi.

Dr. Pankratz served as dean of the new school and as director of the Medical Center until 1961, when he retired and entered a residency program in psychiatry at the University of Tennessee Medical School. He was a practicing psychiatrist in clinics in Tennessee and Kansas until 1972, when he retired a second time and moved back to Oxford to compile a history of medical education in Mississippi.

He was well known for his work as a medical educator. He was the recipient of the Distinguished Service Award in 1952 from the Medical Alumni Association of the University of Chicago and the First Federal Foundation Award in 1961 in Jackson.

He received the bachelor's degree from Bethel College (Kan.) in 1923, and the master's degree and doctorate in anatomy from the University of Kansas. He began medical studies at the University of Kansas, but earned his medical degree in 1938 at the University of Chicago.

Dr. Pankratz was a member of the Mississippi State Medical Association, the American Association of Anatomists, the American Association for the Advancement of Science, the Mississippi Academy of Sciences, the New York Academy of Science, the American Association of Medical Colleges, Sigma Xi research society, Alpha Omega Alpha medical honorary, Nu Sigma Nu medical society and Phi Kappa Phi honor society.

JOURNAL MSMA encourages your participation. Comments, inquiries and suggestions are invited.

Medical-Legal Brief

Housestaff Considered Students Under Labor Act

An action by housestaff associations seeking a declaration that housestaff are employees within the meaning of the National Labor Relations Act (NLRA) and an order directing the National Labor Relations Board (NLRB) to accept jurisdiction over their petitions for certification was properly dismissed, a federal appellate court in the District of Columbia ruled.

The housestaff associations had petitioned the NLRB for certification as collective bargaining representatives of their members. The NLRB dismissed each petition, primarily upon the ground that housestaff are students and therefore not employees under the NLRA.

Dissatisfied with the NLRB's decision, the housestaff associations filed suit in a federal trial court. The court dismissed the action for lack of jurisdiction. On appeal, a panel of a federal appellate court reversed the judgment of the trial court. Thereafter, the federal appellate court granted rehearing and vacated the panel's opinion. The appellate court then affirmed the decision of the federal trial court.

In their appeal, the housestaff associations contended that they were employees under the NLRA because: (1) housestaff are not specifically excluded from the protections of the act, and (2) the NLRB's findings that they "possess certain employee characteristics" required the NLRB to classify them as employees.

The appellate court rejected these arguments, saying: "The task of decision on the facts of each case is assigned to the National Labor Relations Board and in making that decision the Board exercises its informed discretion."

The appellate court agreed with the NLRB's conclusion that residents and clinical fellows are primarily engaged in graduate education training and that the programs in which they participate were designed to allow the student to develop, in a hospital setting, the clinical judgment and proficiency necessary to the practice of medicine in the area of his choice.

Further, the court noted that the defeat of H.R. 2222, a bill designed to include housestaff under the act, cast substantial doubt upon the contention that Congress intended to direct the NLRB to regard housestaff as employees.

The appellate court concluded that the trial had correctly dismissed the case. Four members of the court joined in a dissenting opinion. — Physicians National House Staff Association v. Fanning, Docket No. 78-1209 (C.A., D.C., July 11, 1980)

Seminar Will Present Advances in Perinatal Care

The University of Mississippi Medical Center will host its second annual seminar in perinatal care December 4-5 at the Holiday Inn Downtown in Jackson.

The program, open to physicians, nurses, dietitians, social workers, and technicians, will present advances in the field of perinatal health care. Planners say the presentations will center around the team or multi-disciplinary approach to solving perinatal health care problems.

Guest faculty are Dr. Alfred W. Brann, professor of pediatrics, Emory University School of Medicine, Atlanta; Dr. Avroy Fanaroff, associate professor of pediatrics, Case Western Reserve University School of Medicine, and director of neonatology, Rainbow

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PERINATAL CARE / Continued

Babies and Children's Hospital, Cleveland; Dr. Irwin Merkat, professor of obstetrics and gynecology and director of the Cleveland Regional Perinatal Network, Case Western University School of Medicine, Cleveland; Dr. John T. Queenan, professor of obstetrics and gynecology and chairman of the department, Georgetown University School of Medicine, Washington; Dr. Judith Roepke, associate professor of home economics, Ball State University, Muncie, Indiana; D. John W. Scanlon, associate professor of pediatrics and director of the neonatology division, Georgetown University School of Medicine, Washington; and Dr. Barry S. Schiffrin, associate professor of obstetrics and gynecology, the University of Southern California Medical Center, Los Angeles.

UMC faculty coordinating the seminar are Dr. John C. Morrison, professor of obstetrics and gynecology and director of the division of maternal and fetal medicine, and Dr. Philip G. Rhodes, associate professor of pediatrics and chief of the division of newborn medicine.

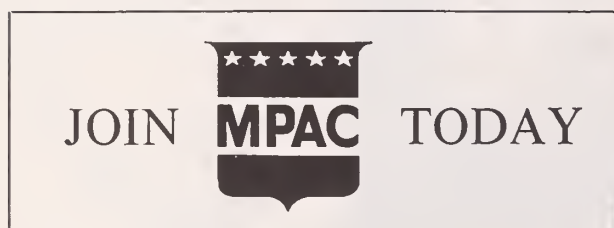
Course fee is \$150 for physicians. The program meets criteria for 12.5 contact hours in Category I of the Physician's Recognition Award. Application has been made for credit from the American Academy of Family Physicians.

JCAH Will Operate National Hotline

The Joint Commission on Accreditation of Hospitals (JCAH) now operates a 24-hour, national hotline. The toll-free hotline number is 800/621-8007.

The hotline was instituted in October to provide responses to inquiries about the Joint Commission and the accreditation process.

A hotline operator will be available from 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday. Calls received at all other times will be recorded, transcribed and returned on the next regular working day.



CYCLAPEN®-W (cyclacillin)

Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Branchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae*

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY. Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

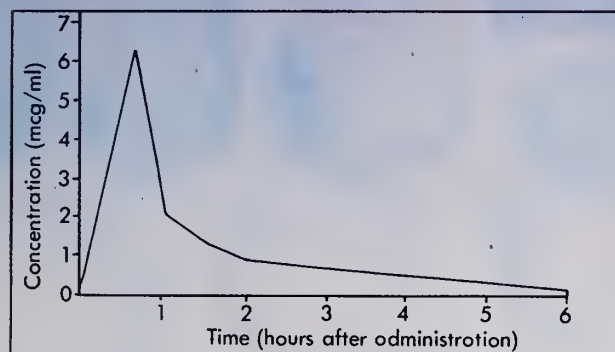
*Dosage should not result in a dose higher than that for adults †depending on severity

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Causative Organism	Bronchitis/Pneumonia†	Na. of Patients
S. pneumoniae	100%	73
	95%	
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92%	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to H. influenzae.	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100%	44
	86%	
<div><div></div> % Clinical Response</div> <div><div></div> % Bacterial Eradication</div>		

†Due to susceptible organisms.

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- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
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*Based on single oral doses of 500 mg cyclocillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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**NEW
NAME**

PERSONALS

WILLIAM BATES of UMC presented a paper at the Central Association of Obstetrics and Gynecology in Minneapolis, MN, Sept. 24-26 and at a University of Tennessee symposium on menopause in Memphis Sept. 17.

ALVIN E. BRENT, JR. and MARCELO J. RUVINSKY of Jackson announce the association of CHARLES H. LANEY for the practice of nephrology and internal medicine.

THOMAS J. BROOKS of UMC spoke at the North Mississippi Medical Center in Tupelo in September.

LARRY W. CARRUTH announces the opening of his office at Omega Medical Arts Building, Suite D, 1500 45th Avenue in Gulfport, for the practice of pulmonary medicine and critical care medicine.

THAD C. CARTER and JOHN R. STRIPLING announce the opening of their office for the practice of urology at 725 Dunbar Avenue, Bay St. Louis.

A. W. CONERLY of UMC recently lectured on pulmonary care at the Golden Triangle Regional Medical Center in Columbus and at the annual meeting of the Missouri Society of the American Association for Respiratory Therapists in Jefferson City, MO.

CLAYTON S. COOK announces the relocation of his office for the practice of surgery and medicine to Medical Arts Building, 405 South 28th Avenue, Hattiesburg.

E. WARREN EVANS announces the opening of his office for the practice of medicine at 4105 Hospital Road in Pascagoula.

W. MEL FLOWERS of UMC represented Mississippi at the House of Delegates assembly of the American College of Nuclear Physicians in Chicago in September.

JOEL R. FLYNT and A. DEAN CROMARTIE, JR. of Hattiesburg have opened the Women's Clinic, 1611 South 28th Avenue, for the practice of obstetrics and gynecology.

ALAN FREELAND of UMC spoke at a meeting of the Atlanta Orthopedic Association in September.

CHARLES J. GRUICH announces the relocation of his office for the general practice of medicine to Coastal Medical Center, Gateway Executive Park, Biloxi.

JAMES HARDY of UMC was guest speaker for the Houston Surgical Society in Houston, TX, Sept. 19-20.

GEOFFREY B. HARTWIG has joined the Hattiesburg Clinic, P.A., for the practice of neurology.

HARPER HELLEMS of UMC was visiting professor in Augusta, GA, in September.

THOMAS P. HOUSTON announces the opening of his office for family practice at Siwell Road at Terry Road in Byram.

I. C. KNOX, JR., of Vicksburg was elected chairman of Vicksburg Hospital's board of directors. He succeeds W. K. PURKS, who served in the post for 23 years. Other officers are KARL HATTEN, vice chairman, and HERMAN E. KELLUM, treasurer.

HERBERT LANGFORD of UMC participated in a satellite symposium between Australia and the United States in New York in September and lectured on salt and hypertension in Stockholm, Sweden, Aug. 20-Sept. 2.

WESLEY L. MCFARLAND of Bay St. Louis is one of 125 physicians nationwide who are the first diplomates of the American Board of Emergency Medicine.

MALLAN G. MORGAN of Natchez recently was named chief of staff of the Jefferson Davis Memorial Hospital.

JOHN MORRISON of UMC recently was guest speaker at the International Symposia on Dysmenorrhea in Chicago, spoke at a meeting of the American Chemical Society in San Francisco, and was visiting professor at Louisiana State University in New Orleans.

DAN R. NORTHEY has joined the Hattiesburg Clinic, P.A., for the practice of gastroenterology.

J. GEORGE SMITH of Jackson was on the faculty at the fall scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery in Anaheim, CA, in September.

ROBERT R. SMITH of UMC presented a paper at a recent workshop on the EC/IC Bypass study in Bordeaux, France, and was an examiner for the American Board of Neurological Surgery in Dallas, TX, Sept. 8-13.

DAVID WATSON of UMC attended the Chapter Chairmen's Forum at the annual meeting of the American Academy of Pediatrics in Chicago in September.

NEW MEMBERS

NASH, BINFORD T., JR., Starkville. Born Hattiesburg, MS, Oct. 3, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned and family practice residency, University Medical Center, Jackson, 1976-79; elected by Prairie Medical Society.

PETERS, WILLIAM H., Hattiesburg. Born Shreveport, LA, Aug. 9, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Spartanburg, SC, elected by South Mississippi Medical Society.

REHAK, EDWARD M., Biloxi. Born Baltimore, MD, July 26, 1924; M.D., Georgetown University School of Medicine, Washington, DC, 1950; interned Bon Secour Hospital, Baltimore, one year; pathology residency, Georgetown University Hospital, 1952-53; pathology residency, V. A. Hospital, Washington, DC, 1953-56; elected by Coast Counties Medical Society.

STEPP, DANIEL J., Lumberton. Born Niles, MI, July 3, 1951; M.D., Loma Linda University School of Medicine, Loma Linda-Los Angeles, CA 1976; interned Florida Hospital, Orlando, one year; family practice residency, same, Jan. 1978-Jan. 1980; elected by South Mississippi Medical Society.

RECOLLECTIONS

In the November 1960 issue of JOURNAL MSMA Dr. G. Swink Hicks, MSMA president, examined rising health care costs. He observed that "the really important aspect to remember is that the 1960 medical care dollar buys drugs and services which couldn't be had at any price in 1935." He noted actual cost savings from medical progress reducing the risk of mortality and number of days lost from work.

Scientific articles included: "Differential Diagnosis of Diverticulitis of the Sigmoid Colon from Carcinoma," by Dr. Fred M. Sandifer; "Castration in Carcinoma of the Breast," by Dr. William L. Thornton; and "Anesthesiology in the Emergency Room," by Dr. L. W. Fabian.

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POSTGRADUATE CALENDAR

Dec. 4-5, 1980

SECOND ANNUAL MISSISSIPPI PERINATAL POSTGRADUATE COURSE

Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Obstetrics and Gynecology Division of Maternal-Fetal Medicine; the Department of Pediatrics Division of Newborn Medicine; the University of Mississippi School of Nursing; and the Medical Center Division of Continuing Health Professional Education.

Coordinators: John C. Morrison, M.D., professor of obstetrics and gynecology and director of the division of maternal-fetal medicine; and Philip G. Rhodes, M.D., associate professor of pediatrics and chief of the division of newborn medicine, University of Mississippi School of Medicine.

Advances in the field of perinatal health care will be presented in this two-day program. Sessions will include effects of obstetric analgesia and anesthesia on the newborn, asphyxia neonatorum, nutrition counseling for pregnant women, the use of ultrasound in obstetrics and prenatal diagnosis of congenital malformation. Fee: \$150 for physicians. Credit: 12.5 contact hours (1.25 CEU) Category I of the Physician's Recognition Award, AMA; AAFP Credit applied for.

Jan. 30-31, 1981

FORENSIC ODONTOLOGY AND PATHOLOGY
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Dentistry Department of Oral Pathology and Oral Radiology, the University of Mississippi School of Medicine Department of Pathology, the Medical Center Division of Continuing Health Professional Education and the Office of the Mississippi State Medical Examiner.

Coordinator: Sigurds O. Krolls, D.D.S., professor of oral pathology and oral radiology and chairman of the department, University of Mississippi School of Dentistry, and professor of pathology, University of Mississippi School of Medicine.

This seminar will include discussions of means of identification dealing with specific and general principles of evidence evaluation. Presentations will emphasize recognition of bite marks and the battered child syndrome. Fee: \$50. Credit: 10.5 contact hours (1.05 CEU) Category I of the Physician's Recognition Award, AMA.

Feb. 5-6, 1981

RENAL UPDATE

Coliseum Ramada Inn, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education. Co-sponsors are Kidney Care, Inc., the Kidney Foundation of Mississippi, the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Coordinator: John D. Bower, M.D., professor of medicine, assistant professor of physiology and biophysics and director, Artificial Kidney Unit, University of Mississippi Medical Center.

This program is a joint conference for physicians, nurses, social workers and dietitians. The physicians' program is designed for the family practitioner, internist and urologist. The faculty will review the physiology and pathophysiology of fluid, electrolytes, and acid-base balance and discuss clinical problems associated with nephrologic disorders. Fee: \$50 for physicians. Credit: 11.5 contact hours (1.15 CEU) Category I of the Physician's Recognition Award, AMA.

FUTURE CALENDAR

Jan. 30-31, 1981

FORENSIC ODONTOLOGY AND PATHOLOGY
University Medical Center, Jackson

Feb. 5-6, 1981

RENAL UPDATE


Ramada Inn Coliseum, Jackson

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.



**Acute pain
is no laughing matter.**

The first prescription for the first days of acute pain Empirin® \bar{c} Codeine #3


Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). 

**For the millions of patients who need the potency
of aspirin and codeine for their acute pain.**

The pain of fractures, strains, sprains, burns and wounds is at its peak during the first three to four days following trauma. The potent action of Empirin \bar{c} Codeine begins to work within 15 minutes of oral administration, an important advantage during this acute pain period. Empirin \bar{c} Codeine has unique bi-level action to attack pain at two critical points: peripherally at the site of injury and centrally at the site of pain awareness.

For the most effective dosage in treating acute pain, begin with... two tablets of Empirin \bar{c} Codeine #2 or #3, every four hours. Titrate downward as pain subsides.

EMPIRIN® with Codeine

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming) 

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.



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CLASSIFIED

PHYSICIANS WANTED. Pediatric and/or family practice physician wanted to help staff Hinds County Health Department Clinic. Ob-Gyn, pediatrician or family practitioners needed to staff health department clinics in areas outside Jackson area. Contact Dr. C. E. Fox, P. O. Box 1700, Jackson, MS 39205 or call (601) 354-6680.

OFFICE FOR LEASE (2,000 sq. ft., available July 1, 1981). Located in professional area of Tupelo, across street from 600-bed North Mississippi Medical Center. Family practitioners or other interested physicians, please contact Frank C. Baker, D.D.S., 810 Garfield Dr., Tupelo, MS 38801 or telephone 601/842-8035 (office) or 601/842-5224 (home).

EQUIPMENT FOR SALE. Burdick EKG; Clay Adams Hematocrit centrifuge. Contact Dr. L. G. Carl, Jackson, MS, 366-8494 (office) or 366-3710 (home).

TWO PRIMARY CARE PHYSICIANS and nurse practitioner needed for two primary health care clinics in rural Itawamba County, MS, operated under a DHHS-PHS Rural Health Initiative grant: (1) fully-renovated, newly equipped clinic and (2) new clinic to be built with FmHA/Rural Health Care program funds in late 1980. Program now provides full-time dental services. Service area approximately 18,750; full-time administrator and social worker. Salary negotiable. Prospects for financial self-sufficiency excellent. Contact: The Urgent Rural Needs, Inc. (TURN); P.O. Box 617, Fulton, MS 38843. Telephone (601) 585-3884.

PLACEMENT SERVICE

Physicians Wanted

OTOLARYNGOLOGY ASSOCIATE desired for ENT practice. Modern clinic near major hospital. Active allergy division. Contact: James E. Harris, M.D., P.O. Box 671, Hattiesburg, MS 39401. Telephone (601) 264-4407 (office) or (601) 584-7420 (home).

PHYSICIANS WANTED TO RENT OR LEASE completely furnished 14-room modern clinic in county seat with population 15,000. New 36-bed hospital and 60-bed

nursing home. Ill health caused physician to vacate clinic after 25 years successful practice. Call (601) 326-2741 between 8:00 a.m.-6:00 p.m.

PHYSICIAN WANTED to take over established general practice in Tunica. Completely equipped office and community hospital available. Located 35 miles from major metropolitan area. Contact: Mrs. W. W. Nobles, Box 307, Tunica, MS 38676; telephone (601) 363-1341.

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

GENERAL PRACTICE opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general

pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single specialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

FAMILY PHYSICIAN seeking a group practice opportunity in Mississippi. Graduate of Mississippi College and University of Mississippi School of Medicine, (1978). Presently serving residency at Roanoke Memorial Hospital. Contact Robert C. Lee, M.D. 2325 Avenham Ave., Apt. #6, Roanoke, VA 24014, or call 703/344-3506.

LOCUM TENENS work wanted — family and general practice, open availability. Contact T. C. Kolff, M.D., (801) 566-1666.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

PHYSICIAN completing training in 1981 seeks general practice location, preferably in shortage area. Contact Kenneth K. Wheatley, Jr., M.D., 1800 Holcombe Boulevard, Apt. 205, Houston, TX 77030.

PEDIATRICIAN desires clinic or ER location in south Mississippi. Presently in training; available January 1981. Contact S. G. Eggen, M.D., 4929 Cleveland Place, Metairie, LA 70003 or call 504/837-3000 (ext. 2436 or 2395).

Index to Advertisers

American Medical Association 242
Alpha Therapeutics Corp. 250
Anderson-Clayton & Co. 14

Boots Pharmaceuticals, Inc. 14A, 14B, 14C, 14D
Burroughs Wellcome Co. 246, 257

Canton Exchange Bank 3
Citizens Bank 11
Coca-Cola Bottling Co. 17
Commodity Resources, Inc. 255

Darkroom, Inc. 251

Harrel Chevrolet-Oldsmobile 255

Janssen Pharmaceutica 16, 17

Eli Lilly and Co. 12

Miss. Medical Fraternal and Educational Society 15
Mississippi Stationery 6

Parke, Davis & Co. 8
Premier Printing 3

Riverside Hospital 4
Roche Laboratories ... second, third, fourth covers, 3, 10A

South Central Bell 10
Southern Environmental Products 243

The Upjohn Co. 10B, 10C, 10D
U. S. Army 7

Wyeth Laboratories 6A, 6B, 252, 253

Thomas Yates 18

IN CONCLUSION

In a cooperative national surveillance effort, the Mississippi Bureau of Disease Control urges that all cases or suspected cases of toxic-shock syndrome (TSS) be reported, so that officials may have the widest possible data base for evaluation of the extent and seriousness of TSS. So far no cases have been confirmed in Mississippi, but officials have conferred with physicians on several suspected cases. Since January more than 100 cases have been reported to the CDC in Atlanta. The mortality rate, originally reported to be about 10%, has been recently estimated at about 5% or less.

There is no evidence of a direct causal connection between artificial food colors and flavors and hyperactivity in children, according to a recent report issued by the National Advisory Committee on Hyperkinesia and Food Additives. The Nutrition Foundation commissioned the five-year, \$1 million investigation because of the public health implications of issues raised by Dr. Ben Feingold in his 1975 book, Why Your Child is Hyperactive. The book incriminated many natural fruits and vegetables as well as artificial food colors and other additives.

Brown cataracts, which represent 40,000 of the 400,000 cataracts which will be removed this year in the U.S., can be prevented, says an Emory University Department of Ophthalmology researcher. Dr. Sidney Lerman, researching photochemistry of the eye since 1968, believes wearing protective glasses to filter out ultraviolet light will prevent brown cataracts. He has also found that photosensitive chemicals in certain drugs, i.e. oral contraceptives, diuretics, antibiotics and tranquilizers, may be involved. Protective lenses would aid the eye's normal protection against such compounds, he says.

Upjohn HealthCare Services will conduct a major campaign to convince nurses to remain in the profession and to persuade more young people to enter it. The 1981 campaign will include expanded advertising, promotion and public relations efforts for nurse recruiting and promoting the image of nursing; a public service film for TV distribution; an expanded employee retention program; and a new scholarship fund. Of the nation's 1.4 million licensed nurses, only about 980,000 are active. The shortage has been felt sharply in recent years because the rapidly expanding elderly population has increased need.

A project directed towards serving the needs of handicapped physicians is attempting to identify those individuals to receive statistical data on their career patterns and the extent to which various handicaps affect their ability to remain in active practice. It is estimated that 4% of all MDs are not in active practice because of a physical handicap, and that 25% of those individuals could be rehabilitated into active practice. Handicapped physicians, active or inactive, are asked to contact F. Zondlo, M.D., St. Paul-Ramsey Medical Center, 640 Jackson St., St. Paul, MN 55101.



For recurrent attacks of urinary tract infection in women

BactrimTM DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require the Bactrim™ 3-system counterattack



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OF MEDICINE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

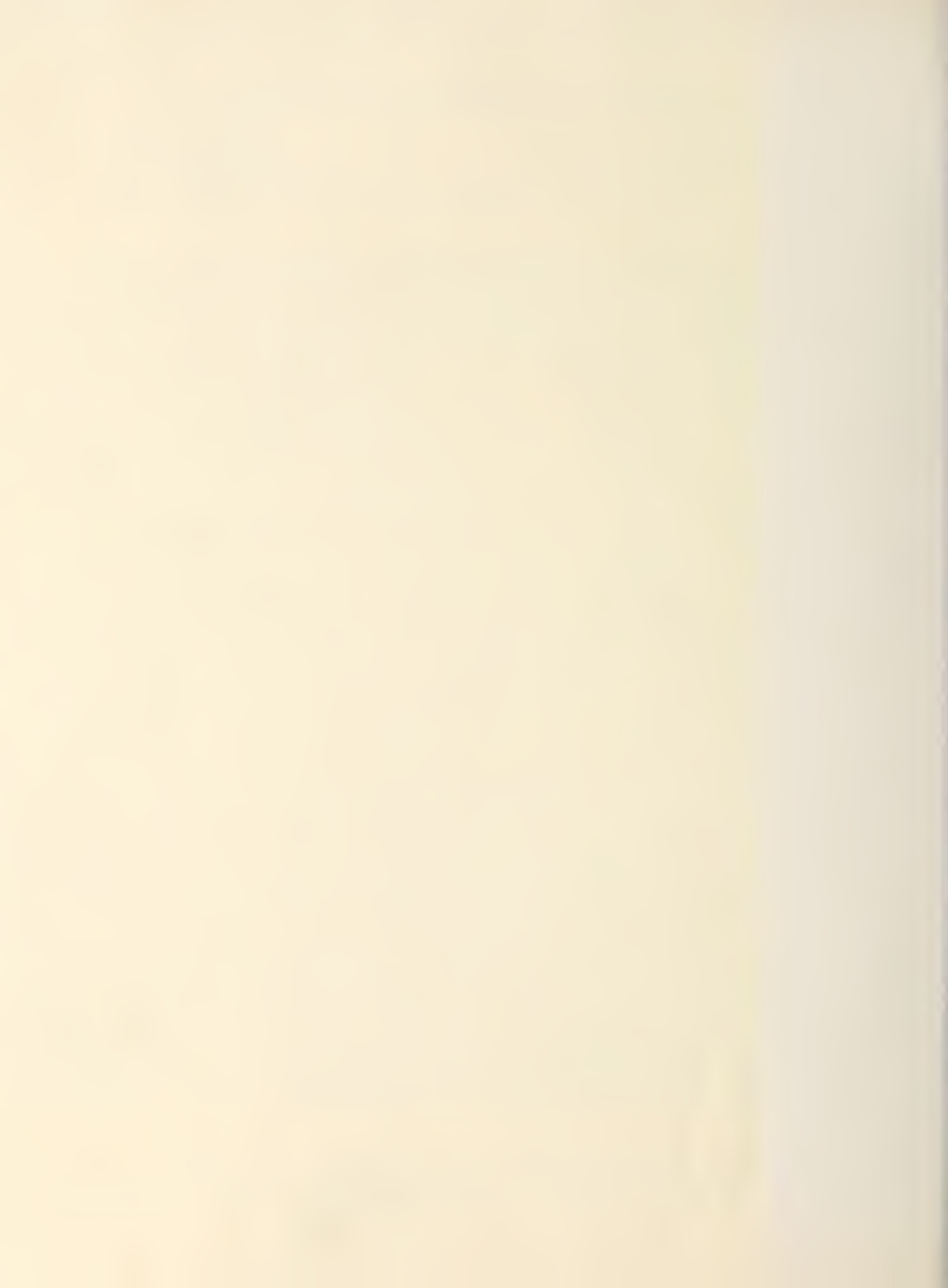
Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has no significant effect on other normal, necessary intestinal flora.



Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.



December 1980

Journal of the
State Medical
Association

Mississippi

(ISSN 0026-6396)

Contents:

Angiodysplasia of the
Colon

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half-life

Just one built-in advantage

Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium® (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough

Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued.

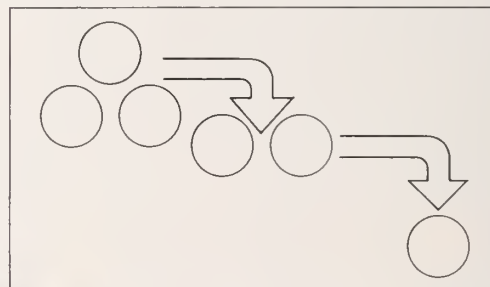
Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for

the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation

When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



*in the management of
symptoms of anxiety*

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets

*effective therapy through
efficient pharmacodynamics*

Before prescribing, please see summary of product information on next page



Valium® diazepam/Roche

3

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, atetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

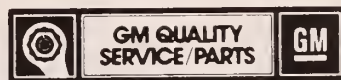
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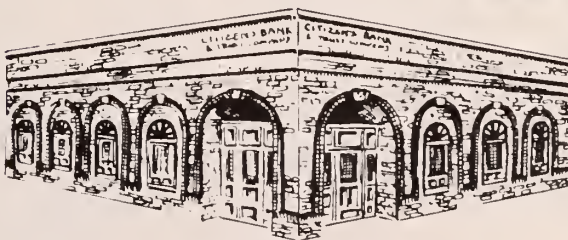


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SUPPOSITORIES/CREAM WITH HYDROCORTISONE ACETATE

#1 prescribed hemorrhoidal product

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NUMBER ONE
IN 1959

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The professional source of
modern anorectal comfort

ANUSOL-HC® SUPPOSITORIES

Hemorrhoidal Suppositories

ANUSOL-HC® CREAM

Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol-HC Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil surface with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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Morris Plains, NJ 07950 USA

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JOURNAL of the **MISSISSIPPI** State Medical Association



December 1980, Volume XXI, Number 12

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CONTENTS

ORIGINAL PAPERS

Angiodysplasia of 259 RONALD E. GRAY, M.D. and
the Colon E. MOSHE IZSAK, M.D.

Radiologic Seminar CCIX: 262 HILTON W. PITTMAN, M.D. and
CT in Orbital Diagnosis WILLIAM F. RUSSELL, IV, M.D.

SPECIAL ARTICLE

Cost-Effectiveness of 268 CHARLES L. MATHEWS
Certificate of Need

EDITORIAL

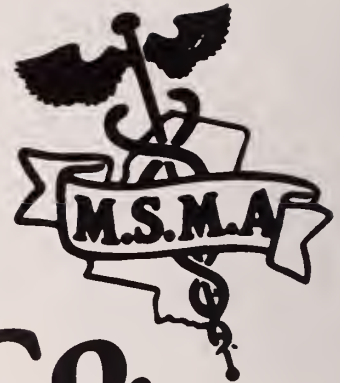
When is Enough, 275 W. MONCURE DABNEY, M.D.
Enough?

THIS MONTH

Auxiliary Page 273 1981 Legislative Day
The President Speaking 274 Election's Impact on Medicine
Medical Organization 277 Physicians' Fees Profiled

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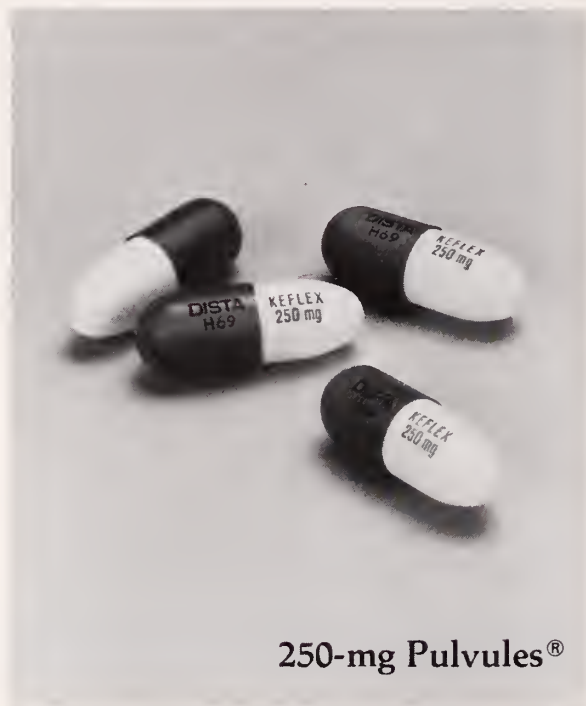
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NEWSLETTER

December 1980

Dear Doctor:

"One of the hazards in arthritis care is the tendency of sufferers to attempt self-treatment for a period of time before seeing a doctor," said Dr. Frederick C. McDuffie, senior vice president for medical affairs for the Arthritis Foundation, in a recent issue of "National Arthritis News." Dr. McDuffie noted that the average arthritis patient waits four years before seeking medical diagnosis and care, thus delaying the benefits of early diagnosis and treatment.

His remarks were in response to a letter to the editor accusing the Arthritis Foundation of being "brainwashed" by the American Medical Association. The reader objected to the statement in Arthritis Foundation literature to "see your physician" and complained that "in reality, most physicians would be of no help."

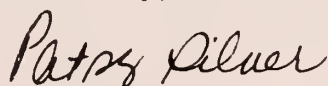
The John A. Hartford Foundation has awarded a three-year, \$650,000 grant to the American College of Physicians for a project to help curb the rising costs of health care. The project, Clinical Efficacy Assessment Program, will evaluate and make recommendations to the medical community on the scientific merit and usefulness of many nonsurgical diagnostic tests and procedures.

The government has reversed its decision to phase out nitrite - the coloring and preserving agent previously alleged to be carcinogenic. An intensive review of the study which prompted the ban revealed the incidence of lymphomas was the same in both groups of animals. Some FDA scientists say then-Commissioner Donald Kennedy failed to follow ordinary review procedures which would have detected the flaw.

Hospital expenditures will reach \$335 billion by 1990 compared to \$97 billion this year, predicts the chairman of American Hospital Supply Corporation. He acknowledged the growth in alternative forms of health care delivery such as HMOs and ambulatory surgical centers, but observed that the majority are hospital-affiliated. Demand for hospital services will increase due to the growing 65-and-older population.

"It is the physician's duty to inform patients of the great dangers of repeated assaults on the skin by harmful ultraviolet light, whether its source is the ancient sun or the new neighborhood suntanning salon," says a recent article in JAMA. The popularity of tanning parlors has increased the need for patient education, says the AMA, pointing to recent warnings by Bureau of Radiologic Health.

Sincerely,



Patsy Silver
Managing Editor

POSTGRADUATE CALENDAR

Jan. 30-31, 1981

FORENSIC ODONTOLOGY AND PATHOLOGY
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Dentistry Department of Oral Pathology and Oral Radiology, the University of Mississippi School of Medicine Department of Pathology, the Medical Center Division of Continuing Health Professional Education and the Office of the Mississippi State Medical Examiner.

Coordinator: Sigurds O. Krolls, D.D.S., professor of oral pathology and oral radiology and chairman of the department, University of Mississippi School of Dentistry, and professor of pathology, University of Mississippi School of Medicine.

This seminar will include discussions of means of identification dealing with specific and general principles of evidence evaluation. Presentations will emphasize recognition of bite marks and the battered child syndrome. Fee: \$50. Credit: 10.5 contact hours (1.05 CEU) Category I of the Physician's Recognition Award, AMA.

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SIPC

Feb. 5-6, 1981

RENAL UPDATE

Coliseum Ramada Inn, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the University of Mississippi School of Nursing and the Medical Center Division of Continuing Health Professional Education. Co-sponsors are Kidney Care, Inc., the Kidney Foundation of Mississippi, the Mississippi Nephrologic Society and the Mississippi Urologic Society.

Coordinator: John D. Bower, M.D., professor of medicine, assistant professor of physiology and biophysics and director, Artificial Kidney Unit, University of Mississippi Medical Center.

This program is a joint conference for physicians, nurses, social workers and dietitians. The physicians' program is designed for the family practitioner, internist and urologist. The faculty will review the physiology and pathophysiology of fluid, electrolytes, and acid-base balance and discuss clinical problems associated with nephrologic disorders. Fee: \$50 for physicians. Credit: 11.5 contact hours (1.15 CEU) Category I of the Physician's Recognition Award, AMA.

March 26-27, 1981

THIRD ANNUAL NEUROLOGY SPRING SYMPOSIUM
Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurology, the Veterans Administration Medical Center Neurology Service and the Medical Center Division of Continuing Health Professional Education

Coordinator: Shri K. Mishra, M.D., associate professor of neurology (part-time), University of Mississippi School of Medicine, and neurologist, Veterans Administration Medical Center.

Guest faculty for this program are Dr. John E. Bennett, chief of the Clinical Mycology Section, LCI, National Institutes of Health; Dr. Donald B. Calne, clinical director, NINCDS, National Institutes of Health; Dr. Kenneth P. Johnson, chief of neurology research, University of California at San Francisco; and Dr. Jay P. Sanford, dean of the School of Medicine, Uniform Services University of Health Sciences. Fee: \$150. Credit: 13 contact hours (1.3 CEU), Category I of the Physician's Recognition Award, AMA.

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 987-4914.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL
DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension
EQUAGESIC[®]
 (meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlorid-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Meclizol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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hours as needed



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(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings).

MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977). Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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DATELINE

Scientific Exhibitors
May Reserve Space

Jackson, MS - Prospective scientific exhibitors are invited to submit requests for exhibit space for MSMA's 113th Annual Session, April 26-30, in

Biloxi. MSMA members presenting scientific exhibits are eligible for the Aesculapius Award for Scientific Achievement. Letters should be sent to MSMA, P.O. Box 5229, Jackson, MS 39216. Requests for space should include the title of the exhibit, names of sponsors, and space requirements.

Ruling Paves Way For
"Wrongful Life" Suits

Los Angeles, CA - Children born with crippling, fatal diseases have the right to sue testing laboratories for "wrongful life," a California appellate

court has ruled. The parents of a 2-year-old girl born with Tay Sachs disease are seeking \$3 million in damages from a laboratory and attending physician for providing allegedly incorrect information that they were not carriers, thus influencing their decision to maintain the pregnancy.

Journal Profiles
Child Abuser

Chicago, IL - To assist physicians in evaluating potential child abusers among their patients, the Journal of Diseases of Children published in a

recent issue a table of characteristics of abusive mothers. Six points marking the abuser are: mother has negative feelings about herself, has unrealistic expectations of herself and her child, is inconsistent, resents rules and regulations, has difficulty finding pleasure in child care, and enjoys authority over others.

ACS Compiles
1980 Factbook

Chicago, IL - National health expenditures increased from \$69.2 billion in 1970 to \$212.2 billion in 1979, an increase of 207%. Private sector expenditures

increased 185%, while public sector expenditures increased 270%. The federal portion of public expenditures increased from \$13.4 billion to \$53.3 billion, or 198%. These are among facts included in the 1980 Socio-Economic Factbook, available free from American College of Surgeons, 55 E. Erie St., Chicago, IL 60611.

AMA Sets Budget
For Fiscal 1981

Chicago, IL - The bulk of expenditures by the AMA in 1981 will be for scientific policy and information (\$25,244,000) and to assure the quality of medical

care (\$11,713,000). The rest of expenditures will be distributed among other missions of the AMA: to represent the medical profession (\$10,968,999); to strengthen organized medicine (\$7,004,000); socioeconomic policy and information (\$5,393,000); and AMA as an organization (\$7,472,000).



Among University of Mississippi School of Medicine alumni attending continuing medical education sessions as part of the annual medical alumni day at UMC were (from right) Dr. Charles Cannon of Philadelphia, Dr. Walter Taylor of Clarksdale and Dr. Berlyn Edwards of Ocean Springs. Guest lecturers included former UMC faculty member Dr. Watts R. Webb (left), now professor of surgery and chairman of the department at Tulane University School of Medicine. Sponsors were the Class of 1961 - Continuing Education Fund of the Medical Alumni Chapter of the University of Mississippi Alumni Association and the Medical Center Division of Continuing Health Professional Education. Medical alumni chapter president Dr. J. Elmer Nix presided.

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Forensic Science Program Set

The role of forensic sciences in identification and the evaluation of criminal evidence is the focus of a University of Mississippi Medical Center seminar in Jackson Jan. 30-31.

Sessions will include various means of identification, recognition of bite marks and characteristics of the battered child syndrome.

Dr. Kenton Hartman, chief of oral pathology at the USAF Medical Center, Keesler Air Force Base, will discuss identification problems encountered in the Canary Island and Guyana mass disasters. Program lectures also include Dr. Faye G. Spruill, medical examiner for the State of Mississippi and UMC clinical associate professor of pathology, and Dr. Sigurds O. Krolls, professor of oral pathology and oral radiology and chairman of the department, UMC School of Dentistry.

AMA Schedules Scientific Meeting

Postgraduate courses, lectures and update workshops will be featured at the American Medical Association Winter Scientific Meeting Jan. 24-26 in Atlanta.

Complete program for the meeting is published in the Oct. 23 issue of *JAMA*.

Genetic engineering and brain hormones will be among the special topics presented by guest lecturers for the assembly. A special program will be offered on the physician's role in nuclear power and possible nuclear accidents.

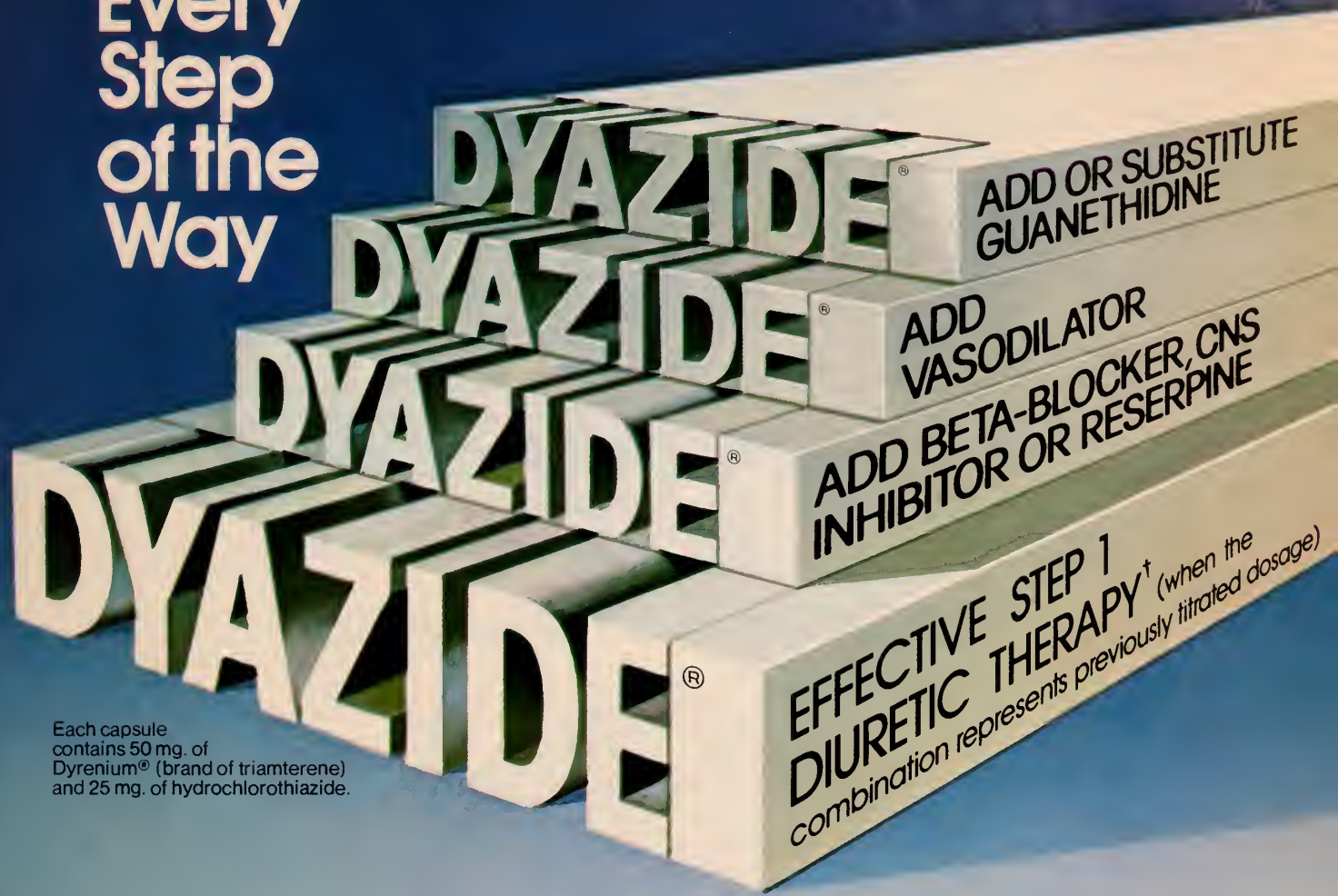
The AMA's annual Conference on Sports Medicine will be held in conjunction with the scientific meeting on Jan. 24. The AMA Auxiliary will present special programs for physicians' spouses during the meeting.

Physicians will participate in lecture sessions and study courses on a wide variety of medical topics at the convention. Study areas will include update on infectious disease, problems facing the American family, gastrointestinal disease, heart disease, pulmonary disease, drug therapy, nuclear medicine, bowel disease, acute diarrhea, cirrhosis of the liver, exercise testing in heart disease, coronary bypass surgery, management of acute respiratory failure, bacterial infections and antibiotics, viral infections, chronic mental illness, behavior problems in children, asthma, emphysema, drug interactions and venereal disease.

Further information on the convention is available from the Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, IL 60610.

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Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, throm-

bocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Anti-hypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with

possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

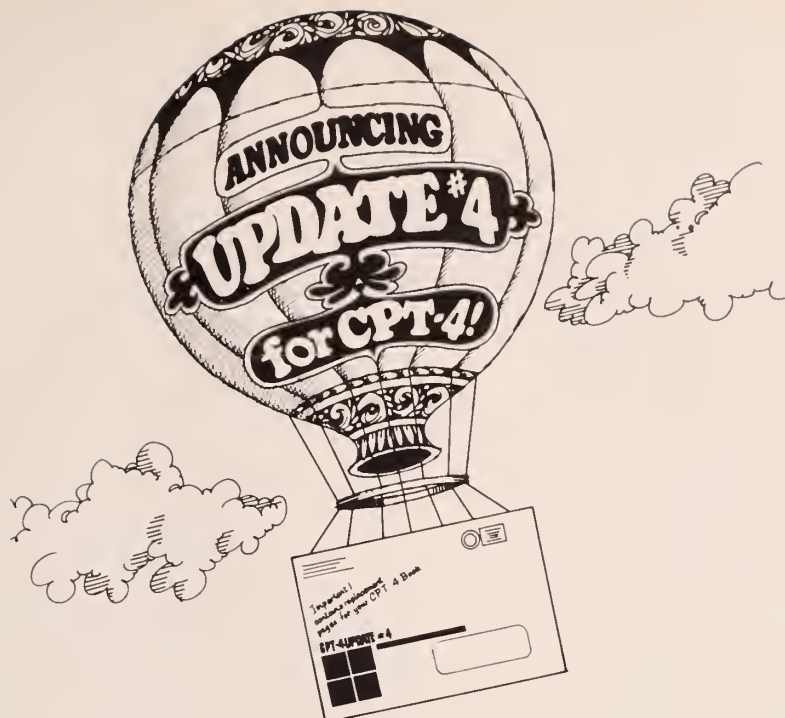
When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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Otolaryngologists Change Name

The American Academy of Otolaryngology changed its name to "American Academy of Otolaryngology — Head and Neck Surgery" during the academy's recent annual meeting in Anaheim, CA. Also, the American Council of Otolaryngology changed its title to "American Council of Otolaryngology — Head and Neck Surgery."

Academy officials said the changes reflect the evolution of the specialty, which originally included the traditional aspects of ear, nose, and throat diseases but now has become a regional medical and surgical specialty of the neck, including allergy, facial plastic and reconstructive surgery, and cancer and related surgery within this part of the body.

UMC Adds to Faculty

Two instructors and an associate professor have joined the centerwide and School of Medicine faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced their appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

Dr. George P. Hemstreet, III, was named an associate professor of surgery (urology) and assistant professor of microbiology. Dr. Jill Woodliff joined the faculty as an instructor in pathology and Dr. Thomas H. Adair was named an instructor in physiology and biophysics.

Dr. Hemstreet earned the B.S. degree at Wake Forest University, did graduate work in biology at Columbia University and received the M.D. degree from Hahnemann Medical College. He interned and took residency training at the University of Oklahoma Medical Center, and took residency training and earned the Ph.D. degree at Duke University Medical Center. Since 1976 Dr. Hemstreet had been assistant professor of urology, microbiology and immunology at the University of Alabama, chief of urology/oncology research at the Veterans Administration Hospital in Birmingham and associate scientist at the University of Alabama Lurleen B. Wallace Tumor Institute.

Dr. Woodliff earned the M.D. degree at the University of Mississippi School of Medicine and had been a resident in pathology there since 1978.

Dr. Adair earned the B.S. degree at Michigan State University and the M.A. degree at Western Michigan University. He earned the Ph.D. degree at the University of Texas Medical Branch where he was McLaughlin postdoctoral fellow.

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Indications

Cyclacillin has less *in vitro* activity than other drugs in the ampicillin class and its use should be confined to these indications. Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment of least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age. Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

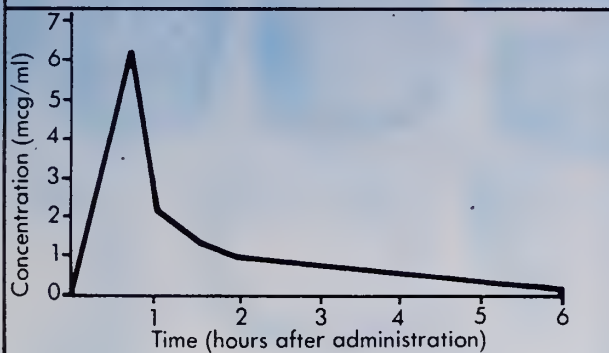
INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
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*Based on T_{1/2} values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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[†]Due to susceptible organisms.

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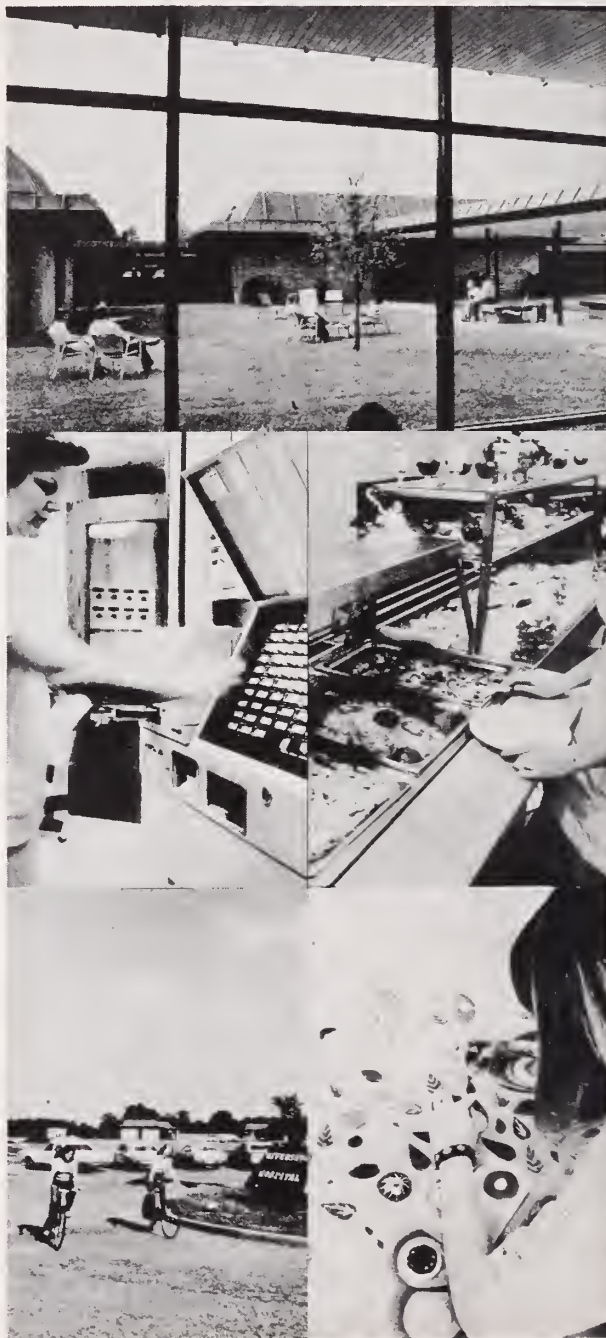
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ORIGINAL PAPERS

Angiodysplasia of the Colon

RONALD GRAY, M.D. and E. MOSHE IZSAK, M.D.

Jackson, Mississippi

A DEGENERATIVE PROCESS affecting the smaller mucosal and submucosal blood vessels of the GI tract, principally of the right colon, has recently been recognized as a clinically significant cause of gastrointestinal bleeding in older persons.¹ A case, seen recently at the University Hospital, of a patient with a history of gastrointestinal bleeding illustrates the clinical course and pathologic anatomy of the condition.

Case Report

A 61-year-old white female was admitted to hospital with complaints of hematochezia and maroon-colored stools. She was apparently well until four days prior to admission when she noted dark red-colored stools and bright red blood mixed in with the stools. These were accompanied by cramping abdominal pains just before having a bowel movement.

She reported three other episodes of bleeding. The first occurred eight years prior to admission and the other two occurred within the last two years. She admitted to having epigastric pains, worse at night and relieved by food. She had never had hematemesis. There was no history of ethanol abuse or aspirin intake. She had not lost weight; her appetite was excellent, and there was no change in her bowel habits. Despite a history suggestive of peptic ulcer disease, she had never been told that this was a problem in the past. She smoked about one pack per day. The rest of the functional inquiry was negative.

She was a slightly obese white female in no apparent distress with blood pressure of 110/70 and a pulse of 80 per minute and regular. Examination of the head and neck and lungs was normal. Car-

diovascular examination revealed a grade II-VI pansystolic murmur heard best at the apex. The abdomen was soft, non-tender without masses or organomegaly and with normal bowel sounds. Rectal examination revealed a normal sphincter tone with maroon-colored stool strongly heme positive. The rest of the physical examination was normal.

The initial laboratory examination revealed hemoglobin of 8.1 g., hematocrit 25, WBC 7,600 with 60% neutrophils and 30% lymphocytes. Serum electrolytes, BUN, creatinine, glucose, protein and liver enzymes were all normal. Serum iron was 7 mg/dl and total iron binding capacity was 357 mg/dl.

Vascular ectasias of the cecum and ascending colon are being recognized with increasing frequency as a cause of lower gastrointestinal hemorrhage in older persons. The authors present such a case. They report that a review of the literature reveals that these are considered to be acquired lesions, rather than congenital malformations.

Chest x-ray and supine erect x-rays of the abdomen were normal. Air contrast barium enema revealed a single cecal diverticulum with no other abnormalities. Upper GI and small bowel follow-through and a technetium scan for Meckel's diverticulum all were normal. Gastroscopy revealed very minimal gastritis. Echocardiogram revealed mitral insufficiency.

She was transfused with four units of packed red blood cells and discharged. She was brought back for an elective colonoscopy. Unfortunately the cecum and ascending colon could not be visualized. The colon distal to the hepatic flexure was normal. The

From the Departments of Pathology and Gastroenterology, University Medical Center, Jackson, MS



Figure 1. Superior mesenteric arteriogram. Right: Vascular blush (large arrow) and early filling vein (small arrow) in small bowel. Left: Abnormal cecal vessels (small arrows) and prominent vein (large arrows).

patient was sent home and returned again a week later with maroon-colored stools. On this occasion the hemoglobin was 12 gm. A repeat colonoscopy all the way to the cecum showed that the entire ascending colon was coated with blood and two cherry red angiodysplasias were visualized in the cecum. One of them was actively bleeding.

The patient underwent angiography to rule out other arteriovenous malformations, and indeed, not only did the A-V malformation in the cecum become visible, but also a jejunal A-V malformation was found (see Figure 1).

At this point the patient was offered surgery, to which she agreed. At laparotomy careful transillumination of the small bowel along with enterotomies and sigmoidoscopic visualization of the entire inner lumen of the small bowel were carried out. Two lesions which were suspicious of A-V malformations were resected in the small bowel. The cecum and ascending colon were also resected.

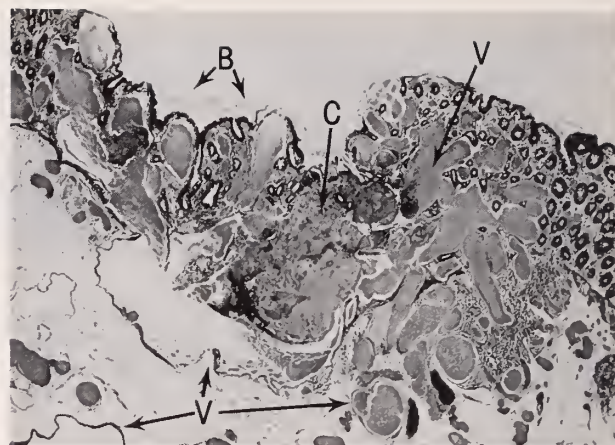


Figure 2. Section from cecal lesion showing abnormally dilated vascular channels (V), blood clot (C), and extravasated barium gel (B). (Hematoxylin and eosin, X 40)

The patient did well and was discharged within eight days of laparotomy. She will be followed for further evidence of bleeding.

Pathology

The resected ascending colon was rushed to the radiology department with a catheter sitting in the ileocolic artery. A suspension of barium sulfate was injected into the catheter and quickly filled the entire vascular system. X-rays of this resected bowel revealed a very prominent vein draining a blob of barium. Upon opening the specimen, two mucosal collections of barium were present in the cecum within 2 cms from each other and approximately 3 cms from the ileocecal valve. Each was approximately 0.5 cms in diameter, and the surrounding mucosa was grossly normal.

A microscopic section of one of these lesions (see Figure 2) shows numerous dilated, thin-walled vascular channels in the mucosa and submucosa. The mucosa was disrupted, and blood clot and extravasated barium gel were apparent, suggesting that this was the site of previous bleeding.

Discussion

Lesions such as those described are being recognized with increasing frequency as a cause of "unexplained" lower gastrointestinal hemorrhage in persons over the age of 60, and have been given the name of "angiodysplasia."^{1, 2} These lesions occur most frequently in the cecum and ascending colon, are often multiple, and are usually less than 5 mm in diameter. They are not detectable by commonly employed diagnostic techniques, such as barium enema, being apparent only upon colonoscopy or

angiography.^{1, 2} They are considered to be acquired lesions and are not associated with vascular malformations elsewhere in the body.³

The vascular anatomy of the colon wall has been described, and an explanation for the development of these mucosal ectasias proposed by Boley et al.³ According to these authors, the underlying pathogenetic mechanism is chronic, intermittent obstruction of submucosal veins due to entrapment of these vessels at points where they traverse the muscular layers of the colon wall. Repeated episodes of obstruction of these submucosal veins results in their dilation, and later, the dilation of the mucosa veins draining into them. Ultimately, precapillary sphincters become incompetent, resulting in small arteriovenous communications, which may rupture and bleed.

That these lesions occur predominately in the right colon is explained on the basis of the law of Laplace, which dictates that at a given intraluminal pressure the tension on the wall of a hollow organ increases directly with its diameter. The greater diameter of the cecum and ascending colon predisposes this region to the sequence of events described above.³

An increased risk of bleeding from cecal ectasias has been reported in patients with aortic stenosis.^{3, 4} However, the precise reason for this association remains unexplained.³ ★★★

2500 North State Street (39216)

Acknowledgement

The authors thank Dr. Nancy Lawhon and the staff of the Department of Radiology, University Medical Center, for their assistance.

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optic nerve glioma, optic sheath meningioma, and in some cases of optic neuritis and other entities.^{5, 6} Of the neoplasms of the optic nerve, optic gliomas are more common than meningiomas.⁶ These spongioblastomas are themselves rare, and occur usually before age 10; up to one half of these gliomas are associated with von Recklinghausen's neurofibromatosis. These tumors are usually identified by CT if there is obvious thickening of the optic nerve.³ The nerve characteristically shows irregular thickening, and calcification within the nerve may be noted.⁶ There may be a multilobulated appearance of the nerve, and the nerve may be enlarged along its entire course.² Displacement or distortion of the globe may occur. The tumor is shown separated from the muscle cone by intervening fat. Although metastases are rare, intracranial extension of the tumor occurs, representing a serious complication. CT permits the important evaluation of intracranial extension of this neoplasm.⁶ There may be noted widening of the optic canal, particularly if high resolution, thin-section scanning is available. Contrast administration reveals variable degrees of enhancement, and its use is particularly important in examining the region of the optic chiasm.⁶

Meningioma of the optic nerve sheath is an even rarer tumor. It is also more common in children.⁵ There is usually a smooth or fusiform enlargement of the optic nerve, either segmentally or involving the

entire nerve. This lesion may be, however, indistinguishable from glioma of the optic nerve.⁶ The lesion may present a sharp interface with the orbital fat. The lesion may extend intracranially, and CT can be useful in evaluating for this occurrence.

The CT scan sometimes indicates optic nerve enlargement in cases of optic neuritis. The main usefulness of CT in evaluation of optic neuritis or optic atrophy, however, is in the exclusion of mass lesions in these patients.⁴

This case of orbital leiomyoma shows the usefulness of CT in follow-up evaluation of orbital lesions after treatment. CT can easily and safely reveal the recurrence, progression or resolution of lesions, involvement of adjacent structures, and the precise location of masses to aid surgical intervention.⁹

Case Three

This 2-year-old male was noted by his family to have enlargement of his right eye, evidence of blindness and a white pupil. Physical examination revealed proptosis of the right eye, dilated pupils and enlargement of both eyes. Fundoscopic examination showed vitreous hemorrhage on the right which obscured visualization of the retina. The left eye showed retinal detachment secondary to a mass lesion of the retina, with areas of calcification. Plain films of the orbits indicated faint calcification on the right as well.

CT evaluation (see Figure 3) demonstrated increased density of the posterior aspects of both globes. No calcium or tumor was noted beyond the globe. The histopathologic examination revealed the expected bilateral retinoblastomas. In addition, there was noted some extension of the right tumor posteriorly within the optic nerve sheath.

Retinoblastoma is a very malignant primary neoplasm of the globe. It is the commonest intraocular malignancy in children. It is important to determine the posterior limit of the tumor, and whether there is intracranial extension. CT is considered indispensable in evaluation of this lesion. CT can readily reveal the size of the intraocular lesion and the extent of spread of the tumor in the retrobulbar space and along the optic nerve in many cases.^{6, 9} CT failed to reveal the optic nerve involvement in this case, however, probably as a consequence of the spatial resolution limitation of the technique. Some 90% of retinoblastomas calcify, and the high contrast resolution of CT permits easy demonstration in these cases. Contrast medium generally has little usefulness in CT of the orbit, particularly in predicting the specific nature of lesions detected.^{3, 5} Contrast medium can improve the visualization of some lesions shown



Figure 3. CT scan section, no intravenous contrast medium administered. Increased density is present within both globes, consistent with calcification. Calcium deposits were not demonstrated beyond the globe by the CT brain scan; however, examination of surgical specimen did indicate microscopic involvement of the right optic nerve by the retinoblastoma.

poorly on non-contrasted scans.^{4, 5} In retinoblastoma follow-up, for instance, contrast can show enhancement of soft tissues in the orbit as an indication of recurrence of the tumor. Although of proven use in retinoblastoma study, CT is less sensitive in evaluating ocular lesions than it is in detecting intraorbital lesions.⁶

Case Four

Proptosis was first noted at age eight years in this male, and slowly progressed over the next five years. Biopsy of orbital tissue revealed an infiltrate predominantly composed of plasma cells, lymphocytes, and histiocytes. This patient presented a complicated medical history, with associated abnormalities of polyclonal gammopathy, adenopathy in various superficial areas, anemia of chronic disease, and plasmacytosis and eosinophilia of the bone marrow. The diagnosis of pseudotumor of the orbit was considered as the most likely of several explanations for the orbital findings. CT scan (see Fig. 4) obtained at age 13 depicted bilateral proptosis, with a soft tissue density mass in the retrobulbar area of each orbit. No specific clues to the exact histopathologic identity of the process were present on the imaging study.

Pseudotumor of the orbit is an often poorly characterized entity or group of entities which can be unilateral or bilateral.¹⁰ It is not a genuine solid neoplastic mass but represents chronic inflammatory or reactive hyperplasia or retrobulbar neoplasm of delicate histology.⁵ Causes for the abnormality include hyperplasias, lymphomas and Hodgkin's disease. The retroorbital mass may extend inside or outside the muscle cone, may involve the lacrimal gland, may cause local muscle enlargement, and may demonstrate an apparent thickening of the posterior coats of the globe, probably secondary to inflammation. Abnormal tissue may fill the entire globe, obliterating the normal structure outlines by an iso-dense mass.³ CT may reveal a diffuse density of the retrobulbar fat. Clinically, the proptosis requires consideration of Graves' disease, hemangioma, lymphomas, or the other less common causes of exophthalmos. CT is of particular value in excluding neoplasm as the cause of the proptosis.⁶ Contrast medium injection may cause an increased density of the retrobulbar soft tissue density, and demonstrate increased prominence of the posterior coats of the eye.^{3, 5}

With CT, and even with examination of biopsy material, the diagnosis can remain elusive; pseudotumor of the orbit could represent a non-specific response to a variety of underlying diseases. CT has its greatest role, therefore, in excluding a true neo-



Figure 4. Scan through the level of the orbits demonstrates bilateral homogenous retrobulbar tissue densities which fill the entire orbital spaces. The soft tissue mass obscures the optic nerve and muscle cone and produces marked exophthalmos. No bone destruction is shown.

plasm and obviating exploratory surgery, permitting a medical treatment trial to be safely monitored.⁶ CT usually does not make possible a clear distinction between the various infiltrative processes which affect the orbit.^{3, 10} This case demonstrates the difficulties often encountered in diagnosing orbital pseudotumor.

CT has made a profound impact on the diagnosis and management of orbital lesions. The imaging modality provides an accurate assessment of the orbit and its contents, and permits evaluation of adjacent regions as well. The accuracy of the method is high, but often the lesions detected present no specific CT findings to suggest their histopathologic identity. In the evaluation of proptosis, CT is particularly useful in excluding the presence of orbital neoplasm and permitting presumptive treatment for orbital pseudotumor without surgical intervention. Other means of investigation of the orbit have been given a secondary, more restricted role since the introduction of CT. These cases are presented to demonstrate the application of CT to ophthalmologic evaluation.

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Cost-Effectiveness of Certificate of Need

CHARLES L. MATHEWS

IN A 1973 REPORT to the House of Delegates of the American Medical Association, the association's Council on Medical Service concluded: "It might be best stated that certificate of need is a two-edged sword. As much as certificate of need is intended to cut costs, avoid duplication, increase accessibility, etc., it can also stifle competition, be time-

consuming and expensive and may not appropriately address the problem of duplication of facilities and services. Competition should be encouraged and new types of incentives should be created for the health and medical providers."

In its review of the research conducted since that time, the Council and its Ad Hoc Committee on Health Planning have found little to refute that earlier conclusion.

The Council's review of the literature on effectiveness of certificate of need programs indicates that over 100 papers and/or studies have been completed, covering a period from 1970 to 1977. This information has been summarized, in part, by Urban Systems Research and Engineering of Cambridge, Mass., and Policy Analysis, Inc. of Brookline, Mass., under a 1978 contract with HEW. The summary, *Certificate of Need Programs: A Review, Analysis and Annotated Bibliography of the Research Literature*, describes much of this research.

One of the more comprehensive studies of CON was published by Davis S. Salkever of Johns Hopkins University and Thomas N. Bice of Washington University under contract with HEW in 1976. Their report, *Impact of State Certificate of Need Laws on Health Care Costs and Utilization*, concluded:

The results of this analysis indicate that Certificate of Need (CON) controls reduced expansion in beds, but increased expansion in plant assets per bed, and had no discernible negative effect on total investment (change in total plant assets). In other words, CON controls altered the composition of investment but not its magnitude, discouraging new beds, but encouraging investment in new equipment and services.

In summary, our analysis points to the (perhaps) surprising conclusion that CON controls have contributed to cost inflation; thus, they have tended to produce the very result which they were designed to prevent. This conclusion must, of course, be treated cautiously due to the limitations of the analyses on which it was based . . . at a minimum, our findings signal the need for a much more

Editorial Note

At its July 1980 meeting the House of Delegates of the American Medical Association received a report from its Council on Medical Service entitled *Cost Effectiveness of Certificate of Need Programs: A Status Report*. Portions of this important report are included in the accompanying article. Responses to the article were solicited by JOURNAL MSMA from persons knowledgeable about the Certificate of Need program in Mississippi. Their remarks may be found on page 272.

The National Health Planning and Resources Development Act (P.L. 93-641) was enacted by Congress in 1974. The teeth of the Act, as conceded by both its proponents and opponents, was to be a federally supported health care cost containment technique called certificate of need (CON). Under certificate of need, health care institutions such as hospitals and nursing homes are required to go through an approval process for construction of new facilities or expansion of existing facilities. The certificate of need program in Mississippi is administered by the Mississippi Health Systems Agency and Mississippi Health Care Commission.

In recent years a number of studies have been undertaken to assess the cost effectiveness of CON programs. Although the results of such studies cannot be termed conclusive, evidence available to date does indicate that certificate of need has had little effect in containing health costs.

"As much as certificate of need is intended to cut costs, avoid duplication, increase accessibility, etc., it can also stifle competition, be time-consuming and expensive, and may not appropriately address the problem of duplication of facilities and services."

thorough and detailed study of the effectiveness of CON regulation as a cost control device. The presumption of its effectiveness is clearly not warranted by the available evidence.

It should be noted that the Bice-Salkever study analyzed the impact of CON over the period of 1967 to 1972, prior to the enactment of P.L. 93-641, when those programs in effect varied significantly from one state to the next.

More recently, the American Health Planning Association (APHA) surveyed Health Systems Agencies as to the outcomes of their certificate of need reviews of hospitals and long term care facilities. Approximately 80% of the 204 HSAs responded to the survey, which encompassed the three-year period 1976 through 1978. A summary of the survey results is illustrated in Table 1.

TABLE 1

<i>Hospitals</i>	
Number of new beds proposed in official CON or Section 1122 applications	11,488
Number of new beds approved	7,840
Number of new beds denied	3,648
<i>Skilled Nursing Home and Intermediate Care Facilities</i>	
Number of new beds proposed in official CON or Section 1122 applications	84,692
Number of new beds approved	65,217
Number of new beds denied	19,475

Thus, the HSAs approved more than 60% of the proposed new hospital beds and approximately 87% of the new beds proposed for skilled nursing homes and intermediate care facilities. It should be noted that the figures quoted in Table 1 from the AHPA survey do not necessarily reflect the number of hospital or long term care beds actually constructed,

since applying for a certificate of need may not indicate either the need for the specific number of beds or the intent of the applicant to construct them.

In terms of applications for purchase of new equipment, according to the APHA survey, the HSAs reviewed CON or Section 1122 applications totaling \$445.8 million and disapproved a total of \$37.5 million or approximately 8%. In applications for renovations of existing facilities, the HSAs reviewed proposals totaling \$4,634.6 million and denied \$340.8 million or approximately 7%. Finally, according to the AHPA survey, the planning agencies officially reviewed \$10.6 billion in proposed capital investment, denying \$2.3 billion or approximately 21%.

The data from the American Health Planning Association survey relate only to CON or Section 1122 applications which were officially reviewed by the health planning agencies. The AHPA survey also attempted to estimate cost savings which resulted from proposed projects on which CON or Section 1122 applications were not filed by health care institutions because of anticipated rejection by the planning agencies. In the opinion of the Council, these latter estimates are difficult to quantify and cannot be considered an accurate measure of the impact on CON in restraining costs. This view has been supported recently by the U. S. General Accounting Office, which has questioned the inclusion of such estimates in the AHPA's cost saving projections.

The federally contracted research summary and other reports have examined a number of general hypotheses concerning the effectiveness of CON. A summary of findings or thinking to date on some of the more significant of these hypotheses follows.

(Editor's note: A list of the specific studies noted is available on request.)

1. Hypothesis: CON will not control cost increases

Evidence from several studies over the period 1973 to 1977 indicates that CON programs have not demonstrated the capacity to restrain cost increases on the whole, although their impact on costs does vary from state to state and depends on the age and sophistication of the CON program. These studies note that CON addresses only one component of hospital cost inflation, and cannot influence such other components as third party reimbursement procedures and provider influence over demand for services (Havighurst, 1973; State of New York, 1977). An analysis of approval rates for services under CON and Section 1122 programs in 20 states also noted that projections of need used by review agencies were based on currently perceived levels of efficiency and placed a ceiling on capacity, not costs. The same study showed that more than half of the states and agencies surveyed place a much higher priority on improving the quality and distribution of health services than on containing costs (Lewin, September, 1975).

2. Hypothesis: The CON process will be controlled by providers, protecting existing providers and reducing competition and efficiency

Some researchers have argued that providers will dominate the CON process for one of two reasons (Noll, 1975; Havighurst, 1973; Posner, 1974; Schlenker and Ellwood, 1973). The "capture theory" argues that regulation is an institution proposed and supported by regulated industries as a means of supplanting competition, and that the regulators become, in effect, a tool of the industry. The "political-economic theory" assumes that regulators attempt to serve some concept of the public interest, but find it difficult to identify this interest because the society contains groups with conflicting goals, some of whom are in a better position than others to provide information to regulators, influence legislators or overturn regulatory decisions in court. While the evidence demonstrating provider

control of CON processes is not conclusive, some case studies indicate that provider control, in whatever form, must be considered. For example, researchers point out that state hospital associations have generally favored CON controls (Macro Systems, 1974; Curran, 1974), while others point out that, with few exceptions, provider reactions to regulatory decisions have been relatively moderate (Codman, 1977). In addition, some researchers have suggested that higher approval rates by review agencies for expansion projects than for new facilities demonstrates a dominance of such agencies by established providers and a bias against new entrants.

Another study (Sapolsky, 1977) suggests that provider dominance of CON process can be diluted by state bureaucracy, consumer members of HSA boards and by HSA staff. The degree of provider dominance of the CON process may also be influenced by such factors as the character of local providers and their position on health planning, the personalities of the consumers on HSA boards and the determination of the state to restrain increases in hospital costs. Although the evidence of provider control is not clear cut, provider influence on the regulators, and upon those who control the regulators, does appear to impact on the CON process and, in the long range, on its effectiveness.

3. Hypothesis: CON will favor the expansion of politically potent institutions at the expense of smaller ones

There is some evidence that medical centers or medical school-affiliated organizations with highly specialized services are virtually exempt from effective review and control under CON (Lewin, September, 1975; Britton, 1975). Another study of CON and Section 1122 programs found that political and organizational dynamics are always more decisive than the technical aspects of planning in implementing such programs, implying that need determinations tend to be political (Codman, 1977). There is also limited evidence to suggest that CON decisions tend to discriminate against proprietary hospitals and nursing homes, as opposed to non-profit or public institutions (Lewin, 1975; Cares, 1975; Britton, 1975; Bicknell and Walsh, 1975).

4. Hypothesis: CON will be expensive to administer

Several studies indicate that the administrative costs of the CON program and the costs of compliance tend to reduce or even eliminate any cost savings realized by CON controls (Havighurst, 1973; Noll, 1975; Kinzer, 1977). Additional research is needed to better quantify the administrative and compliance costs of CON, including costs resulting from additional institutional time devoted to planning, collection of data for use in CON applications, the need for legal assistance and higher construction costs resulting from delays due to the CON process.

5. Hypothesis: CON will stifle innovation in delivery mechanisms such as HMOs

The relatively slow growth of such alternative delivery mechanisms as HMOs, surgicenters, free standing ambulatory care facilities and emergency centers has been ascribed by some writers to the stifling effect of the CON process (Havighurst, 1973; Noll, 1975; Hyman, 1977). However, the evidence that CON, in and of itself, has a dampening effect on innovation in delivery systems is not compelling. In fact, one study indicated that health planners usually react simply on a "yes/no" basis when a CON application is submitted, rather than exploring the possibility of less costly alternatives or the use of shared services. This would seem to indicate that CON does little to either stimulate or stifle innovation (State of New York, 1977).

It is also difficult to argue that CON stifles the development of HMOs when P.L. 96-79 virtually excludes certain types of HMO inpatient facilities from planning authority review and places other restrictions on planning agency reviews of HMO applications designed to prevent these agencies from posing barriers to HMO development.

6. Hypothesis: Individual CON agency board members will favor health facilities' growth in their own areas

Evidence is again incomplete, but preliminary findings indicate that HSA consumer board members, in particular, tend to support technological and capital investment based on parochial interests (Codman, 1977; Lewin, 1975). These decisions may be encouraged since the financing for local services often is received from outside the community, i.e., Medi-

care/Medicaid. Thus, the cost impact is diffused while the service benefit is concentrated. Another study, however, points out that consumers on an HSA board may not be typical in that they may have been selected in part for their ability to rise above parochial interests (Altman, 1977).

7. Hypothesis: CON programs will be hampered by the difficulty of developing standards

The lack of generally accepted standards and criteria on which to base certificate of need decisions is a common theme of the literature on this subject. The lack of consensus on appropriate criteria is best illustrated by the response to the National Guidelines on Health Planning published in 1978. More than 70,000 negative comments on the Guidelines were received by the Department of Health, Education and Welfare prior to publication. A detailed rationale for the specific resource standards contained in the Guidelines has yet to be provided; yet the criteria contained in the Guidelines are commonly found in the Health Systems Plans developed by HSAs and are used by the agencies in reviewing CON applications, although the standards may not be directly applicable to the local area.

Subsequent to the findings of the AMA's Council on Medical Service discussed in this article, another study of the health planning program in five New England states was released.

This study, *An Integrated Approach to Evaluating the Impact of Health Planning in New England*, was conducted by the Codman Research Group, Inc., under contract to the Department of Health and Human Services. Included in the findings of the report is the following statement: "The health planning system . . . is best viewed in the context of the federal government's effort shared by some states to control health care costs; contrary to predictions at the time the health planning law was enacted the program has neither been captured by health providers, nor had an effective control on health care institutional expansion; and the health resource allocation process is accomplished primarily through political bargaining." The study also notes that the health planning program is ineffective as a regulatory program even though the majority of resources have been concentrated in that area. ★★★

(Ed. note: Responses to the preceding article may be found on page 272.)

Commentary

SIRS: I appreciate your sharing a copy of the article entitled "Cost Effectiveness of Certificate of Need." The article is interesting, provocative, and presents in summary the findings and conclusions of several studies on CON. I would like to make a few comments on the article.

I agree that an excessive amount of health planning activity has been devoted to CON as a cost containment measure with very limited proven results to date.

This emphasis continues despite our admitted problems with defining need.

In my opinion, the excessive emphasis on CON and other review and control processes under P.L. 93-641 have diluted the priorities, time, and interest of health planning agencies to the detriment of constructive systems-oriented planning for addressing major health problems of our citizens or for addressing deficiencies in the accessibility, availability or cost effectiveness of our health care delivery system.

A review of the current health plans will reveal, in my judgment, an absence of any plan component which is useful for state policy guidance or commitment.

I believe that a CON program can produce long-term positive results and containment of costs through limiting duplication of high technology services within our communities and through avoiding construction of certain specialized facilities which drain off those services which non-specialized hospitals must provide — the "skimming of cream" phenomenon.

I would agree, however, that to date we have placed entirely too much emphasis on the "controls" of health planning and far too little emphasis on development of plans for improvements in our health status or in our health care delivery systems.

P.L. 93-641 is a comprehensive and very complex law which contains provisions to address a multitude of perceived deficiencies and problems affecting our health status and our health delivery systems.

In its efforts to provide involvement and input from providers, consumers and public officials at local, regional and state levels, the act sets up multiple interrelating agencies and authorities with an almost unbelievable set of processes and procedures

to do anything. In my opinion, the act can never work as intended due to its tendency to fail of its own bureaucratic inertia.

In the meantime, I feel that it is our obligation to do our best to make CON work as a state function for the reasons cited above.

ALTON B. COBB, M.D.
State Health Officer

SIRS: Thank you for inviting my response to the article entitled, "Cost Effectiveness of Certificate of Need."

The authors of the paper did not present evidence that Certificate of Need should cease to exist. What they did suggest was that CON is generally not as effective as it could be. With this latter conclusion I agree completely. Both nationally and in Mississippi, a causal relationship between the existence of CON and reduced costs cannot now be satisfactorily demonstrated. CON is a relatively new program and persons working in the field recognize that improvement is needed.

What I can assure you is this: If Certificate of Need and 1122 were completely abolished, effective today, and (for-profit) facilities could be built without hindrance, the effect on many of Mississippi's non-profit hospitals would be devastating. I believe there is a place for profit-making, non-profit, church, and public facilities in this state and elsewhere. With abolition of CON, however, any serious student of health care economics can see the potential for acceleration of the "cream skimming" phenomenon whereby competition for the paying patient would intensify and the cost of care for the patient less able to pay would be further absorbed by the private patients, insurance companies, and taxpayers.

It is my contention, then, that it is to the advantage of all concerned to make the Certificate of Need process work, and work well. We should attempt to implement CON with sensitivity and good judgment and with a minimum of red tape and unnecessary regulation.

THOMAS J. BROOKS, III
Executive Director
Mississippi Health Care Commission

Mississippi State Medical Association Auxiliary

1981 Legislative Day

All of us see things happening daily in our state and nation that distress us. Some of these things affect us directly by adversely influencing the orderly practice of quality medicine by our spouses. This in turn affects all the citizens of our state, who deserve the best medical care. It therefore behooves us to educate ourselves to the problems and then to address and try to solve the problems. One of the best methods is through the legislative process.

The MSMA Auxiliary members are presently contacting their senators and representatives to attend a luncheon at the Holiday Inn Downtown in Jackson on Wednesday, Jan. 28, 1981. The luncheon will be in conjunction with the January Auxiliary Board meeting, the theme of which is "A Day with the Legislature." We plan to attend a session of the Senate or House of Representatives, or possibly both, in order to acquaint ourselves with the way our legislative system works. This will be an opportune time to meet our legislators and let them know of our support and interest in their elected positions. By becoming better educated in the area of policy making, we can better serve the people of Mississippi by bringing them the best medical care available anywhere. We are planning to have as our guests, Gov. William Winter, Lt. Gov. Brad Dye and Speaker of the House C. B. "Buddie" Newman.

In recent years MSMA has supported legislation on various subjects that daily affect the medical community as well as the general population. MSMA-backed bills have done everything from reduce the statute of limitations on malpractice actions to permit physicians to form their own professional liability carrier. Last year, an MSMA-supported bill created a new Board of Medical Licensure which is composed of physicians nominated by MSMA and appointed by the governor. In addition to supporting bills favorable toward medicine, MSMA stands in opposition to many bills each session that would allow persons to "practice medicine" without the proper education and training.

As you can see, we do have a significant impact on the way medicine is practiced in this state. I would like to urge each and every member of MSMA and MSMAA to become more involved in the field of medical legislation. Let your senators and representatives know your feelings on important topics. I would also encourage the attendance of all MSMAA members at our "Day With the Legislature." More details will be announced in *Distaff*.

MRS. BEN F. MARTIN
Legislative Chairman
MSMA Auxiliary





The President Speaking

PAUL H. MOORE, M.D.
Pascagoula, Mississippi

Election's Impact on Medicine

As I sat down at Rotary the day after the elections, a more elderly and informed member said, "Doc, how could the pollsters be so far wrong?" Of course, he was talking of the landslide victory of Ronald Reagan as the next President of our country. With Reagan receiving the majority of the popular vote, even with a fairly strong Third Party candidate, I believe that the American people have spoken loudly and clearly that they want a just and respectably run government. No more pie in the sky; no more giveaway programs to those who find it advantageous to learn how to avoid work rather than to learn a vocation. We all know that there must be programs and aid for those people who cannot supply their own needs. Yes, there must be medical services for those same people. No one is or should be against that; after all, that is what this country is about.

What does this election mean to the medical profession? What does it mean to those people who were perhaps fighting and hoping for a comprehensive health care system? I believe that it means that the medical profession has been given a mandate to "get your act together" and not only continue to give good medical services to the American people, but to make it even better and more available at an affordable cost.

How can we do this? First, we can do this by being better organized and having a common spokesman. This allows us to have the same goals; therefore, we can spend more time doing those things for which we are trained, rather than fighting among ourselves. Actually, most of our infighting is for better services to our patients. We just cannot decide how and who can achieve this service best.

We need to stop and take stock of ourselves. This election, in my opinion, gives us the needed time to get our act together and to become more solidified so that we may determine the destiny of medicine. We must realize that the public (I think rightfully so) is expecting and demanding more of medicine. Medicine today includes much more than what we know or have known as disease processes. Now it has been broadened to include the well-being of an individual in most any category — spiritual, physical, and mental. Are we ready for this role? We had better get ready, for it is on us.

(continued on page 276)

EDITORIALS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

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When Is Enough, Enough?

An 85-year-old female on Medicaid was admitted to a hospital because she felt dizzy when she first stood up. Her history included mild hypertension, arthritis of her hips and back, and occasional bouts with "gas." This represented one of many hospital admissions for the patient for one or more of the above symptoms. She remained in the hospital for eight days and had chemistry profile, C.B.C., E.C.G., urinalysis, a G.I. series, including gallbladder and barium enema (the only recorded indication for the latter being three loose stools while in hospital). Before discharge she was given a brain scan, which required an ambulance trip to the facility located some distance away.

A 79-year-old Medicaid recipient has known hypertension for many years, and had a recorded B.P. of 240/120 in 1953. Over the years she received sometimes intensive but frequent sporadic therapy for this condition. During the ensuing years she developed osteoarthritis to the extent that she could no longer keep house and for the most part was totally dependent on her family. Her renal deficit gradually worsened to the point that she was put on dialysis. One son, a self-employed, small produce farmer and paper wood cutter, must leave his work three days each week to transport the patient to and from the kidney center.

An 83-year-old female nursing facility patient gradually developed senile mental deterioration until she was vegetative. She required spoon feeding and could not recognize her family. She was not even aware of her environment. One night she developed fever and some respiratory difficulty, and was hospitalized in intensive care. Her condition deteriorated, and when she developed cardiac arrest, the code alarm was sounded and the team made every effort to defibrillate and resuscitate her.

These are not isolated incidents. Are we truly discharging our obligation to society? When is enough enough — and at what price?

W. MONCURE DABNEY, M.D.
Editor

Medico-Legal Brief

U.S. Fails to Enjoin Board From Disciplining Physician

An action by the federal government to prevent the Composite State Board of Medical Examiners of Georgia from taking disciplinary action against a physician in the National Health Service Corps (NHSC) should be dismissed, a federal trial court in Georgia ruled.

The NHSC was created by federal law to provide physicians and other health professionals for underserved areas. The physician was licensed to practice medicine in the state of Georgia and was assigned to a Georgia location. Among his responsibilities as a commissioned officer in the NHSC was the supervision of a physician's assistant. The physician's assistant was certified by New York but not by Georgia. Counsel for HEW had informed him that a Georgia certificate would not be necessary since it was not required under the policy of the NHSC.

On September 28, 1978, the physician was notified by the state board that a hearing would be held to determine what action should be taken against him for permitting an unlicensed person, the physician's assistant, to practice medicine in violation of Georgia law. After the hearing, the Board found that the physician had violated state law by allowing his assistant to write prescriptions without his co-signature and by knowingly aiding, assisting and advising him to practice medicine contrary to Georgia law. He was given a six-month probated suspension of his license.

The federal government then filed suit to enjoin the Board from taking any disciplinary action against the physician and to declare its rights on the assignment and licensing of NHSC personnel within the state. The trial court said that it would abstain from acting and dismissed the complaint. The court acknowledged the contention that disciplinary action against the physician by the Board would impair the efforts of the NHSC but noted that the physician was represented by Justice Department attorneys and the state court was competent to resolve the federal con-

MEDICO-LEGAL BRIEF / Continued

stitutional questions. The court said that the federal interest in providing unhindered health services to medically unserved areas was important. However, that federal interest was not greater than the interest of the state in assuring that its citizens were prescribed medications only by those licensed by it to do so. — *U.S. v. Composite State Board of Medical Examiners of the State of Georgia*, 487 F.Supp. 495 (D.C., Ga., March 27, 1980)

The President Speaking

(continued from page 274)

Where does all of this begin? In my opinion this must originate in the local or county society and filter upward. In essence, it must start in the individual physician's office. We must take time to talk to our patients and find out just what the problem is. We must start with an education process. I believe this must expand into the public school system. We must instruct and teach the public about moderation in or abstinence from those things which we know are not conducive to the well-being of the patient. We must set an example. We need to stress the consequences of (1) obesity, (2) alcohol and drug abuse, (3) smoking, and (4) self-inflicted trauma.

If health education is to be taught in the public school system, then it should be the medical profession which decides what and how it is to be taught, not that of educators. If it is not taught and emphasized properly, I am afraid it will be a waste of the taxpayers' money. It must be given the same status as science, math or English.

To accomplish the things that we must in medicine, we must have a strong voice and then proceed with strong actions. We must be organized and together, not only in numbers but in our thoughts. We must have the common goal, regardless of which

specialty of medicine we practice. Above all, we must have our patients' welfare as our number one goal.

Be sure to join the MSMA, AMA, and the Auxiliary for your wife. We must also increase our Political Action Committee (PAC) membership, not only in numbers but in the amount of money we contribute. If we think that our time is all that is wanted or needed in the political arena, then we are suffering under delusions.

There are those who say that we will have a surplus of physicians by 1985 and surely by 1990. If this is the case, we must protect every facet of medicine from those who would like to practice medicine through legislation and not education. We must first of all protect our patient from this; but, we also must protect the profession and ourselves. We must be able to say to the advocates of socialized medicine that we not only can do it better, we can do it far more efficiently. Although we should realize that we perhaps have the same goals as they, we should recognize that our methods for achieving those goals are far apart. We will continue to know a person as a trusted friend and patient, and not as a number.

Medicine is a great profession; let's keep it that way. Medicine, however, did not progress to the point that it is today by people sitting idly by. It is where it is today because of the hard work and dedication of the conscientious physician who sees that in most cases his patients' needs are met and somehow finds time to take part in the well-being of his community affairs, including local, state and national issues. This type of individual is a must in organized medicine. We must have them as members of our organization. Busy people get things done. Fellow physicians, let's get on with the task at hand. We should vow to ourselves that we will become one of the strongest organizations in this country so that we can assure the American public that they will continue to have the best health care service in the world.

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MEDICAL ORGANIZATION

Physicians' Fees, Services Profiled in AMA Publication

The AMA has published its annual *Profile of Medical Practice* which contains data on physician services in 1979.

The AMA study compares selected practice patterns of physicians in the East South Central Census Tract (Mississippi, Alabama, Kentucky, Tennessee) with national patterns (indicated in parentheses).

According to the AMA data, the average office based physician in our census area practiced 51.8 hours per week compared to a national average of 49.7 hours per week. By specialty the figures were: general practice, 52.6 (48.2) hours; internal medicine, 55.6 (51.8) hours; surgery, 49.9 (52.7) hours; pediatrics, 51.3 (48.3) hours; ob-gyn, 55.3 (52.2) hours.

Physicians in our census tract also had an average of 158.5 patient visits per week compared to a national average of (122.7 patient visits per week). By specialty the figures were: general practice, 218.2 (157.7) visits; internal medicine, 139.5 (117.5) visits; surgery, 149.8 (115.9) visits; pediatrics, 176.6 (138.9) visits; ob-gyn, 135.1 (126.0) visits.

Data gathered on fees in the AMA study reveal that physicians in the East South Central Census Tract charged an average fee of \$25.89 for an initial office visit compared to a national average of (\$30.41). By specialty the figures were: general practice, \$18.62 (\$18.21); internal medicine, \$38.30 (\$38.18); surgery, \$22.48 (\$29.04); pediatrics, \$17.53 (\$21.06); ob-gyn, \$30.33 (\$30.70).

The average fee for a followup hospital visit in our census tract was \$20.12 compared to a national average (\$25.56). By specialty the figures were: general practice, \$16.54 (\$19.06); internal medicine, \$18.97 (\$25.11); surgery, \$20.18 (\$24.91); pediatrics, \$16.86 (\$23.32); ob-gyn, \$20.07 (\$27.03).

Comparison of the AMA study data on professional fees with Medicaid and Medicare recognized fees in Mississippi reveals the following:

	AMA ¹ Study	MS ² Medicaid	Medicare ³ Area 1	Medicare ³ Area 2
Initial Office Visit	\$25.89	\$12.00	\$15.00	\$16.70
Followup Hospital Visit	\$20.12	\$ 6.00	\$ 8.20	\$12.40

1. Based on average fees.

2. Based on fixed fee schedule.

3. Based on 75th percentile of customary charges.

Dr. Morgan Named Director Of Medical Licensure Board

Dr. Frank J. Morgan, Jr. has been named to a six-year term as executive officer of the Mississippi Board of Medical Licensure. Dr. Morgan, who earned the M.D. degree from Tulane University School of Medicine and a masters degree in public health and health care administration from the University of Texas, had been serving as acting director of the board since its formation in July. He previously served as director of the Medical Licensure Division when it was part of the Mississippi State Board of Health.

Other members of the licensure board are: Charles R. Jenkins, M.D., Laurel, chairman; George D. Purvis, Jr., M.D., Jackson, vice chairman; R. Faser Triplett, M.D., Jackson, secretary; Woody Davis, M.D., Meridian; Robert Townes, M.D., Grenada; W. W. Walley, M.D., Waynesboro; Gilbert Mason, M.D., Biloxi; Matthew J. Page, M.D., Greenville; and John F. Lucas, Jr., M.D., Greenwood.

Dr. Hardy Assumes Presidency Of American College of Surgeons

Dr. James D. Hardy, chairman of the Department of Surgery at the University of Mississippi Medical Center, assumed the presidency of the 42,000 member American College of Surgeons during their annual meeting October 23 in Atlanta.

The Mississippi surgeon is internationally known for his contributions to organ transplantation, shock and other surgical research.

A native of Birmingham, Dr. Hardy is an alumnus of the University of Alabama and received the M.D. degree from the University of Pennsylvania.



Dr. Hardy

Dr. Hardy is past president of the American Surgical Association, the Society of University Surgeons, the Society of Surgical Chairmen, the Southern Surgical Association and the Society for Surgery of the Alimentary Tract, of which he was a

founding member. He was also a founding member of the International Surgical Group, and currently is president of the United States Chapter of the International Society of Surgery. He is on the five-member executive committee of the International Society of Surgeons headquartered in Brussels, Belgium. He has also been a member of the Council of the American Association for Thoracic Surgery and vice chairman of the American Board of Surgery.

Professor of surgery and department chairman

Jackson County Citizens Honor Dr. James Thompson



Dr. James T. Thompson, left, of Moss Point receives from Edward A. Khayat, president of the Jackson County Board of Supervisors, a resolution of tribute passed by the supervisors. Numerous community leaders attended special ceremonies held recently to pay tribute to Dr. Thompson for his many years of service to his profession, his community, the county and the public. Dr. Thompson, a past president of MSMA, is retiring after 41 years in the practice of medicine. (Photo courtesy of Jerry Moulder of The Mississippi Press.)

since the Mississippi Medical Center opened in 1955, Dr. Hardy has played a major role in the growth and development of the Medical Center. He was recognized for his contributions to medical education, care and research and for distinguished service to the state as a 1968 recipient of the First Federal Foundation Award.

Dr. Hardy has been visiting professor and invited lecturer in more than 60 universities in the United States, France, Germany, Sweden, Australia, Scotland, Brazil, Peru, Mexico, Argentina, England and Italy. The author or co-author of more than 500 scientific articles, 14 books and producer of 40 movies of surgical techniques, Dr. Hardy is listed in *Who's Who in America* and *American Men of Science*.

He serves as editor of *The Rhoades Textbook of Surgery* and recently of *Advances in Surgery*. He is on the editorial boards of *American Journal of Surgery*, *Surgery*, and the *World Journal of Surgery*.

DEATHS

BYNUM, GUSTAVUS A., Hattiesburg. Born Laurel, MS, Oct. 17, 1911; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1942; interned University of Virginia, Charlottesville, one year; surgery residency, University of Texas Medical Branch, John Sealy Hospital, 1948-1952; anatomy fellowship, University Medical Center, Jackson, MS, 3 years; died July 12, 1980, age 68.

HAYS, ARTHUR V., Gulfport. Born Hattiesburg, MS, March 13, 1913; M.D., Louisiana State University School of Medicine, New Orleans, 1937; interned Charity Hospital, New Orleans, one year; EENT residency, Louisiana State University Medical Center, New Orleans, 1938-41; died Oct. 4, 1980, age 67.

HUGGINS, ISAAC C., Jackson. Born Waynesboro, MS, Nov. 6, 1893; M.D., Tulane University School of Medicine, New Orleans, 1920; interned University Hospital, Oklahoma City, OK, one year; Emeritus member of Mississippi State Medical Association, and American Medical Association; died Oct. 5, 1980, age 86.

McLEAN, D. W., Laurel. Born Meridian, MS, Jan. 7, 1917; M.D., Jefferson Medical College, Philadelphia, PA, 1942; interned Jeff Davis Hospital, Houston, TX., one year; died Oct. 14, 1980, age 63.

PERSONALS

JOHN G. ATWOOD of Meridian announces the relocation of his office for family practice to Meridian Regional Hospital, Highway 39 North.

T. N. BRADDOCK spoke on preventive medicine and costs at a meeting of the West Point Rotary Club.

J. C. CHAUVIN and GARY GALLANT have opened their office for general practice at 401 South Chestnut Street in Aberdeen.

JOHN CLIFTON GOUDELOCK of New Albany was named a fellow of the American College of Surgeons.

A. FOSTER HEBERT announces the opening of his office at 202 Kirkwood in Picayune for the practice of ENT, facial plastic surgery and inhalant allergy.

WAYNE A. HUGHES of Hattiesburg announces the relocation of his office for the practice of family medicine to 103 Aldersgate Circle.

MARK H. LEIFER has joined Rush Medical Group in Meridian for the practice of internal medicine.

ROBERT A. LITTLE of Biloxi was elected treasurer of the board of directors of the Tulane Medical Association.

EDWARD M. LOWICKI announces the opening of an

MSMA Auxiliary Conducts Annual Fall Workshop



Guest speakers at MSMA Auxiliary's recent Fall Workshop in Jackson were Mrs. Wayne C. Brady of Greenville, SC, vice president of the AMA Auxiliary, and attorney David Allen of Ocean Springs, MS. Auxiliary president Mrs. Curtis Roberts of Brandon, left, and president-elect Mrs. John Estess of Hollandale, right, welcomed the visitors. (Photo courtesy of Damian Morgan, Jackson Daily News.)

additional office for the practice of general, thoracic, cardiovascular surgery and oncology at Suite 348, Crossgates Medical Plaza, in Brandon.

DAVID A. MAKEY has joined Rush Medical Group in Meridian for the practice of general surgery.

DAVID B. MOORE, JR. and MARY ELLIS PACE have joined Internal Medicine Associates of Tupelo, 245 South Madison Street. Dr. Moore will practice pulmonary medicine and Dr. Pace will practice internal medicine.

EDWARD R. NORTH, JR. of Jackson has been reelected president of the National Exchange Club Foundation for the Prevention of Child Abuse.

EDWIN R. ORR, III, has opened his office for family practice and internal medicine at Suite B, 1800 Hill Drive, Grenada.

MICHAEL L. PALMER has joined L. Z. BROADUS of Purvis for the general practice of medicine.

JUDITH G. PARKER and SUSAN E. PARKS announce the opening of their office for the practice of pediatrics at Suite 2500, Crossgates Medical Plaza, Brandon.

STEVE PARVIN of Starkville was recently named a fellow of the American College of Surgeons and was elected chief of staff at Oktibbeha County Hospital.

The Pearl River College Board of Trustees paid special tribute to JOE POWELL of Poplarville with a resolution recognizing his 27 years of service and support of the college.

SIDNEY PROSSER has associated with J. EDWARD HILL, JOHN M. ESTESS and WILLIAM H. SPRAGINS for the practice of family medicine at Hollandale Clinic.

ONEY C. RAINES was elected chief of staff at Memorial Hospital of Gulfport. Other officers are LEONARD BALL, vice chief of staff, and FRANK L. SCHMIDT, secretary-treasurer.

HENRY J. SANDERS of McComb was elected chief of staff of Southwest Mississippi Regional Medical Center. Other officers are JOHN MORGAN, chief-elect and LAMAR BURROW, secretary-treasurer.

JACK SARTIN of Clarksdale was elected president of the medical staff at Northwest Mississippi Regional Medical Center. MELVIN EHRLICH is the new vice-president and THAD RODDA is secretary.

FORREST T. TUTOR and THOMAS J. McDONALD announce the relocation of their offices for the practice of neurosurgery to 1080 South Madison, Tupelo.

Negotiating Personal Contracts

(Editor's Note: The American Medical Association's Department of Negotiations regularly publishes "Negotiations Update," a newsletter dealing with physician negotiations. The following article is reprinted from the September 1980 issue.)

The staff of the Department of Negotiations is continually reminded of the necessity for reading documents before signing them. Some who propose and write contracts occasionally alter the proposals when they put them in writing. Reading carefully before signing is the only way to discover any unacceptable deviations. Once a document with altered clauses is signed, the signers are obligated to fulfill it. And, unless the contract contains agreed-upon procedures for making changes or corrections, the altering party will undoubtedly insist on the other's carrying out its terms.

During consultations in recent months, staff has noted more nontraditional phrases appearing in contracts being presented by hospital administrations to hospital-based physicians. These contracts seem to emphasize the term "independent contractor." Through the use of unclear terminology, redundancies, and vague adjectives and word combinations, some contract writers are apparently attempting to acquire the benefits of an employer-employee relationship without having the obligations of an employer.

Also noted in recent months is a disturbing change in hospital relationships with hospital-based specialty groups. Hospitals are apparently trying to write contracts that, if terminated by the administration for any reason, deprive the physician-contractor of due process as a member of the medical staff. The basis appears to be a questionable understanding of Standard I and interpretative material in the "Medical Staff" section (page 93) of the 1980 *Accreditation Manual for Hospitals (AMH)* of the JCAH. That standard is:

"The medical staff shall assure that each member is qualified for membership, and shall strive to maintain the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges, and the periodic in-depth reappraisal of each staff member."

The interpretation of Standard I in the AMH includes the following paragraph:

"Hospital and medical staff bylaws must provide that any physician or dentist whose engagement by the hospital requires membership on the medical staff as described above shall not have his medical staff privileges terminated without the same due process provisions as must be provided any other member of the medical staff *unless otherwise stated by contract.*" (Emphasis added.)

The phrase "as described above" refers to a part of the interpretation that states:

"Physicians and dentists engaged by hospitals either full-time or part-time in administratively responsible capacities, but whose activities include clinical responsibilities, must have achieved and maintained medical staff membership through the same procedures provided for all medical staff members . . . Continued medical staff membership *may or may not* be made contingent on continued engagement by the hospital and *should be so stated in the individual's contract with the hospital at the time of employment.*" (Emphasis added.)

Some administrators are apparently using interpretations relating exclusively to employed staff physician administrators while insisting that those same physicians are "independent contractors." The Department of Negotiations staff does not wish to dissuade any full- or part-time hospital-based physician from changing his status from an independent contractor to an employee, if that is what he wants. However, problems can result from careless reading of contracts. Note that many formerly fruitful and excellent handshake relationships are now being written into complex legal language to protect what the hospitals believe are their interests.

But physicians' interests are involved, too. So physicians should regard the contract tender as a proposal from the administration. And they should let the offerers know immediately that what has been presented will have to be negotiated, with the negotiations centering around at least a few specifics. These should include such items as:

- Authority appropriately matched with the responsibilities;
- No contract termination without just cause and due process;

- Due process procedure for contract problems;
- Delineation of roles and relationships with various administrators (i.e., hospital medical director, specialty or other department heads, etc.);
- Relationships where more than one contract is involved (i.e., partnerships, groups, employed physician specialists, etc.);
- Exclusivity;
- Professional liabilities for the contractor and for the hospital;
- Compensation arrangements and levels;
- Authority for participation in decisions about hospital services and equipment; and
- Other items unique to the local situation.

Above all, do not let anyone force an immediate signing. Postpone negotiations until an advisor or attorney has had a chance to read the proposal carefully. Plan counterproposals carefully, deleting or rewording undesirable proposals. Prepare arguments both for your newly developed counterproposals and against the hospital's unacceptable proposals. Then the scene is set for negotiations.

MSMA and MMFES Schedule Malpractice Seminar

A malpractice seminar will be conducted on Saturday, Feb. 7, 1981, at the Coliseum Ramada Inn in Jackson. The seminar, co-sponsored by MSMA and the Mississippi Medical Fraternal and Educational Society, will feature a panel of speakers who will discuss malpractice from both a medical and legal standpoint.

Scheduled speakers include: William Liston, a trial lawyer from Winona, who will present a plaintiff's view of malpractice; Tom Stennis, a defense lawyer from Gulfport, who will present the perspective of the defense; Circuit Judge Andrew Baker of Charleston, who will present a judge's view; Dr. Robert S. Brittain of Colorado, an authority on risk management, who will discuss medicine's view; and Dr. Glen Wegener of Clarksdale, who will describe experiences of a defendant. A panel discussion will conclude the session.

Early registration is recommended. Registration for the seminar will be limited to 200.



Patients who visited the Children's Medical Group in Jackson on Halloween were greeted by staff members dressed in costumes. The staff report that the children enjoy the masquerade, which has become an annual affair. Seated, from left, are: Dotty McGee, Raggedy Andy; Willie Simpson, lion; Donna Presley, scarecrow; Rae Galloway, clown; and Linda Fisher, cat. Standing, from left, are: Linda Dykes, pumpkin; Rachel Perry, clown; and Dr. Jim Hendrick, witchdoctor.

PLACEMENT SERVICE

PRIMARY CARE PHYSICIANS sought for Sardis, MS. Medical offices and other practice support available. Community hospital. Contact Mr. Herring, North Panola Regional Hospital, Sardis, MS 38666 or call (601) 487-2720.

GENERAL PRACTITIONER or family practitioner to join established solo practitioner. Excellent medical facilities, state college community, JCAH approved hospital. Call or write Dr. G. Leroy Howell; Hospital Drive; Starkville, MS 39759. Phone (601) 323-2911.

ASSOCIATE OR PHYSICIANS interested in independent practice in family medicine, internal medicine, pediatrics, surgery or ob-gyn. Suite ready for lease or will build to suit tenant. Located in rapidly growing Northeast Jackson suburban area. Contact Robert Cates, M.D., Cates Plaza Clinic, Ridgeland, MS or call (601) 856-6000.

SURGEON to associate in active practice in town of 15,000 in Southwest Mississippi. Drawing area 75,000. Contact Marvin Harvey, M.D., Box 728, McComb, MS 39648.

GENERAL PRACTICE opportunity in group practice on Gulf Coast. No initial investment. Excellent hospital facilities. Contact: W. E. Calhoun, M.D. and W. P. Warfield, M.D., P.O. Box 764, Moss Point, MS 39563; telephone (601) 475-8821.

Situations Wanted

BOARD ELIGIBLE ANESTHESIOLOGIST seeks practice location. M.D. from M. P. Shah Medical College, Jamnagar, India, 1971. Anesthesiology residency at University of Tennessee, 1980. Married. Contact Mohanlal L. Patel, M.D., 5289 Queen Anne Dr., Memphis, TN 38134.

PEDIATRICIAN desires opportunity to practice pediatric nephrology with a limited amount of general pediatrics. Concluding a three year fellowship in June 1980. Contact: James R. Matson, M.D., University of Iowa Hospital, Department of Pediatrics, Iowa City, IA 52242.

PEDIATRICIAN completing military obligation in November seeks practice opportunity in single spe-

cialty, multi-specialty or partnership position in community of 20,000-80,000 population. Contact David W. Drennen, M.D., 9998A Saint Onge Avenue, Ellsworth AFB, SD 57706.

GENERAL PRACTITIONER seeks practice location in Mississippi. Graduate of Ohio State Medical School, 1960; married, one dependent. Presently in general practice in Dayton, OH. Contact Carl R. Hildebrand, M.D., 5151 Hoagland-Blackstub Rd., Cortland, OH 44410.

FAMILY PHYSICIAN seeking a group practice opportunity in Mississippi. Graduate of Mississippi College and University of Mississippi School of Medicine, (1978). Presently serving residency at Roanoke Memorial Hospital. Contact Robert C. Lee, M.D. 2325 Avenham Ave., Apt. #6, Roanoke, VA 24014, or call 703/344-3506.

CARDIOLOGIST seeks solo or group practice opportunity in hospital-based consultative practice. Completing fellowship in June 1981. Contact Amar DeSai, M.D., 1003 Fenley Ave., Louisville, KY 40222.

PEDIATRICIAN and PATHOLOGIST (husband and wife) seek practice opportunity. Available July 1981. Contact Michael M. Lessner, M.D. and Evelyn J. Diehl, M.D., 1920 Cheremoya Ave., Los Angeles, CA 90068.

PATHOLOGIST especially interested in coagulation and blood banking seeks hospital-based position. Contact Daniel Williams, Jr., M.D., 77 Rippowam Rd., Apt. A, Stamford, CT 06902.

PHYSICIAN completing training in 1981 seeks general practice location, preferably in shortage area. Contact Kenneth K. Wheatley, Jr., M.D., 1800 Holcombe Boulevard, Apt. 205, Houston, TX 77030.

PEDIATRICIAN desires clinic or ER location in south Mississippi. Presently in training; available January 1981. Contact S. G. Eggen, M.D., 4929 Cleveland Place, Metairie, LA 70003 or call 504/837-3000 (ext. 2436 or 2395).

PEDIATRICIAN seeks practice location upon completion of residency in July 1981. Contact J. K. Angrish, M.D., 1222 Vincent Ct., #4, Flint, MI 48503.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addic-

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

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Alpha Stimulation

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Blood Pressure*

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*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer-Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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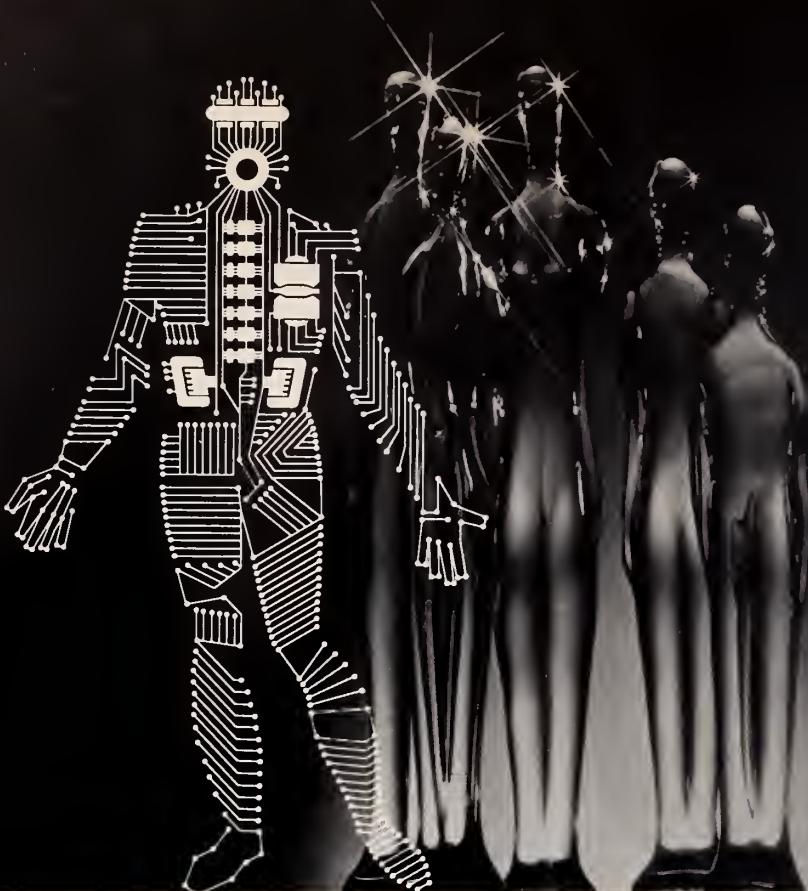
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Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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INDEX

VOLUME XXI

January-December, 1980

- **EDITOR**

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SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; "PM," Practice Management Mailbox; the asterisk (*) indicates an original article in the Journal,

and the author's name follows the entry in brackets. "Deaths," "Personals" and "New Members" are indexed under the letters "D," "P," and "M" respectively.

Matter pertaining to MSMA is indexed under "Mississippi State Medical Association." For the author index see page 288.

A

Abdomen

abdominal scanning for retained gastric antrum [Sanders and Flowers] *143-RS

Abuse, Child

child abuse in Jackson, MS [Levy] *1

Accidents

physicians urged to become involved in safety education [Lockey] 103-E

Advertising

DOC organization uses counter advertising to promote good health habits, 14-N

newspaper editorial opposes physician advertising, 34-N

American Academy of Pediatrics

Dr. Jeanette Wilkins delivers Claud L. Batson Memorial Lecture during state chapter meeting, 14-N

Mississippi chapter conducts annual meeting, 13-N

nominate Dr. Blair Batson for vice president, 229-N

American Association of Medical Assistants

state chapter installs new officers, 176-N

American College of Obstetrics and Gynecology schedules reproductive endocrinology course in Jackson, 209-N

American College of Surgeons

Dr. Hardy assumes presidency, 277-N

Hattiesburg physician is course director for second annual trauma symposium, 87-N

American Hospital Association

urges hospitals to set up staff procedures, 104-N

American Medical Association actions of House of Delegates summarized, 204-N

annual meeting is opportunity for solving problems [Moore] 172-PP

involvement, increased membership urged [Moore] 244-PP

plugs PSRO program, 228-N

poll shows credibility with public remains high, 107-N

voice of organized medicine [Moore] 198-PP

American Medical Association Auxiliary report of 1980 convention [Roberts] 223-AP

AMA-ERF needs physician support [Martin] 85-E

Arrington, Lamar death of former MSMA president reported, 58-N

Arthrography shoulder arthrography [Weathersby] *93-RS

Atkinson, Jack A. memorial lecture series established, 38-N

memorial lecture conducted, 175-N

receives posthumous Robins award, 127-N

Auxiliary to MSMA conducts 57th annual session, 131-N

officers elected, 175-N

past presidents honored at luncheon, 131-N

plans 1981 legislative day, 273-AP

president reports on 1980 AMA Auxiliary convention [Roberts] 223-AP

program for 57th annual session, 80-N

sponsors legislative luncheon, 59-N

workshop stresses total fitness, 16-N

B

Batson, Blair E. nominated for vice president, American Academy of Pediatrics, 229-N

Blake, Thomas M. authors electrocardiography book, 136-N

Board of Medical Licensure governor makes appointments to new board, 153-N

Bone solitary bone lesion from unsuspected renal carcinoma [Wade and Lawhon] *115-RS

Book Reviews *Current Surgical Diagnosis and Treatment: 4th Edition*. By Dunphy and Way. [George] 35-BR

What You Should Know About Medical Lab Tests. By Raymond Vermett. [Nicholas] 121-BR

Brain arachnoid cysts [Smith] *145

CT in intracranial abscess [Pittman and Russell] *167-RS

Brumby, Paul honored by Abbott Laboratories for 50 years of practice, 59-N

C

Cancer

aspiration cytology in diagnosis of breast cancer [Martin] 151-E

Cardiovascular disease

management of thoracic duct fistula following insertion of cardiovascular prosthesis [Maples et al] *233

Mississippi Baptist Medical Center schedules cardiovascular seminar, 176-N

nuclear imaging of the heart [Ball] *23

Certificate of Need cost-effectiveness [Mathews] *268

Chemotherapy prolonged remission of metastatic rhabdomyosarcoma: the use of chemotherapy and nutritional support [Balducci and Steinberg] *181

Child Health Assurance Program expected to pass Congress, 43-N

Chiropractic chiropractor held liable for damages, 174-MLB

Colon angiodysplasia of the colon [Gray] *259

colon obstruction secondary to adhesive splenomegaly [Didlake et al] *237

Computer Assisted Tomography CT in intracranial abscess [Pittman and Russell] *167-RS

CT in orbital diagnosis [Pittman] *262-RS

CT scans in diagnosis of arachnoid cysts [Smith] *145

in diagnosis of obstructive jaundice secondary to carcinoma of the gallbladder [Barrett] *49-RS

D

Deaths

Arrington, Lamar, 58

Beech, Thomas Richard, 157

Bynum, Gustavus A., 278

Cameron, Robert A., 206

Cromeans, Claude, 157

Forman, Robert L., 177

Harrell, Felix James, Jr., 230

Hays, Arthur V., 278

Hudson, J. Manning, 177

Huggins, Isaac C., 278

Hume, Charles R., 60

Jobe, Louis Harmon, Jr., 206

Johnston, Hugh Haralson, 206

McLean, D. W., 278

Montgomery, Daniel C., Jr., 157

Owen, George W., 230

Pankratz, David S., 250

Rayner, Hugh S., Jr., 230

Shipp, John Martin, 230

Taintor, Charles W., 109

Wesson, Ray L., 109

Doctors Ought to Care (DOC)

health groups endorse state chapter, 15-N

uses counter advertising for prevention, 14-N

Duodenum

superior mesenteric artery syndrome [Burkhalter and Blumenthal] *240-RS

Dying

physician's thoughts on death and dying [Derrick] 103-E

E

Electrocardiography

Dr. Blake authors book, 136-N

Endocrinology

course scheduled, 209-N

Esophagus

spontaneous rupture of the esophagus [Defore and Netterville] *214

Eye

intraocular lens implantation [Rayner] *45

F

Federal Trade Commission

broadens its attack on medicine [Gable] 84-PP

report of Congressional efforts to limit FTC activities [Lockey] 33-E

Senator Thad Cochran commended for co-sponsoring amendment to FTC authorization bill [Sammons] 85-L

Fees

fees, services profiled, 277-N

physicians' fees — ethical considerations [Murphy] 226-PM

usual, customary, and reasonable fees [Wright] 245-E

G

Gallbladder

obstructive jaundice secondary to carcinoma of the gallbladder [Barrett] *49-RS

ultrasonography of the gallbladder [Hale] *4-RS

Garrett, Hallie biographical sketch of early woman physician [Price] *171

Graduate Medical Education National Advisory Committee (GMENAC)

predicts physician surplus, 249-N

H

Health

Carter proposes cuts in health programs, 108-N

issues in 1980 Democratic party platform, 220

issues in 1980 Republican party platform, 221

MSMA president outlines election year health issues [Moore] 224-PP

review of Mississippi health care — 1979, 18-N

Health Care Costs effect of national health insurance on health care costs [Mathews and Larson] *51

hospital group purchasing cuts costs, 58-N

Health Care Financing Administration (HCFA) issues Medicare regulations on diagnostic procedures, 41-N

Health, Education and Welfare, Department of court bars release of HEW Medicare list, 35-MLB

new campaign promotes second opinions [Mathews] 33-E

proposes national health planning goals, 40-N

Health Maintenance Organizations (HMO) former HMO medical director speaks to Central Medical Society, 248-N

overview of HMO programs, 99-N

participation urged in MSMA conference on HMOs [Lockey] 173-E

Health Manpower National Health Service Corps: Boon or Boondoggle? [Silver] *29

Health Planning government involvement in medicine [Moore] 150-PP

HEW outlines national health planning goals, 40-N

Health, Public gains and needs outlined in review of Mississippi medicine — 1979, 18-N

needs discussed at national public health conference, 153-N

Health Systems Agency (HSA) Virginia HSA publishes physician directory, 108-N

Heart nuclear imaging of the heart [Ball] *23

Hemodialysis court rules family can discontinue elderly patient's hemodialysis, 225-MLB

Herring, Preston S. honored by Abbott Laboratories for 50 years of practice, 42-N

Hill, J. Edward named president of Mississippi Academy of Family Physicians, 209-N

Hospitals decision to deny privileges to podiatrist ruled reasonable, 152-MLB

group purchasing cuts costs, 58-N

report no difficulties from closing of nuclear waste disposal sites, 17-N
state's rates lowest in nation, 229-N
urged by American Hospital Association to adopt staff procedures, 104-N

I

Infant Mortality

maternal and child health in Mississippi (Cobb) *95
perinatal regionalization: it works for all of us [Morrison and Rhodes] *137

Insecticides

physicians urged to report pesticide poisoning incidents, 87-N

Insurance, Health

insurers' methods of determining usual, customary, and reasonable fees [Wright] 245-E
physician assistance sought in processing General Motors claims [Entmacher] 173-L

J

Jail Health

(see Mississippi State Medical Association)

Jaquith, W. L.

retires as director of Mississippi State Hospital at Whitfield, 17-N

Joint Commission on Accreditation of Hospitals (JCAH)

announces national hotline, 252-N

Journal MSMA

reader comments on new cover design, 226-L
recollections articles on pages 22, 44, 66, 92, 114, 255

K

Kidney

profile of the renal colic patient [Elliott et al] *163
solitary bone lesion from unsuspected renal carcinoma [Wade and Lawhon] *115-RS

L

Laetrile

court rules constitutional rights do not include laetrile, 104-N

parents denied laetrile use, 89-MLB

Legislation

a close look at political involvement [Gable] 8-PP
Carter proposes cuts in national health program funding, 108-N

MPAC needs physician support [Murphy] 245-E

MSMA's legislative program outlined, 37-N
summary of health bills passed by 1980 Mississippi Legislature, 154-N

Letters to the Editor

comments on House of Delegates action on use of stimulant drugs [Brandon] 10-L

comments on Journal MSMA cover [Smith] 226-L
comments on state Medicaid program [Nicholas] 55-L
deplors lack of professional courtesy [name withheld] 10-L

respond to certificate of need article (Cobb and Brooks) 272-L

seeks physician assistance in processing General Motors claims [Entmacher] 173-L

Senator Thad Cochran commended for efforts on behalf of amendment to FTC authorization bill [Sammons] 85-L

Litigation

physician sues another physician for libel, 10-MLB

Lucas, John F., Sr.

honored by Greenwood Hospital, 158-N

M

Malpractice

American legal system: friend not foe [Murphy] *190
avoiding malpractice [Eppes] *186

avoiding malpractice suits is topic for MMFES annual meeting, 87-N

consultant sued for advising no malpractice grounds, 200-MLB

current cases parallel several Mississippi cases, 103-MLB

long waits in doctor's office can contribute to patient dissatisfaction, 247-PM

MSMA and MMFES schedule seminar, 281-N
need to understand the rules [Sutherland] *192

organization and operation of Mississippi Medical Fraternal and Educational Society [Dunn] *194

preparation for testimony in a malpractice case [Montgomery] *193

physician describes experiences in malpractice suit [Derrick] 199-E

Maternal Mortality

case report XIX of maternal mortality study [Godfrey] *117

maternal and child health in Mississippi [Cobb] *95
perinatal regionalization: it works for all of us [Morrison and Rhodes] *137

Medicaid (see also Mississippi Medicaid Commission)

problems in Medicaid delivery [Mathews] 151-E
expected CHAP legislation will have impact on state Medicaid program, 43-N

reader comments on Medicaid program [Nicholas] 55-L

Medicare

court bars release of HEW list, 35-MLB
regulations are issued on diagnostic procedures, 41-N

Medical Practice (see also Practice Management Mailbox)

effect of politicians' solutions on medical profession [Dabney] 55-E

FTC broadens its attack on medicine [Gable] 84-PP
Mississippi physicians have longer hours and lower fees [Mathews] 9-E

Medico-Legal Brief

chiropractor liable for damages, 174-MLB
consultant sued for advising no malpractice, 200-MLB

court bars release of HEW Medicare list, 35-MLB
court denies parents laetrile, 89-MLB

family can discontinue elderly patient's hemodialysis, 225-MLB

hospital reasonable in denial of privileges to podiatrist, 152-MLB

housestaff considered students under labor act, 251-MLB

medical-legal cases in other states parallel Mississippi cases, 103-MLB

physician sues another physician for libel, 10-MLB
U.S. fails to enjoin Board from disciplining physician, 275-MLB

Members, New

Abney, Richard S., 39
Arias, Manuel, 39
Arnett, William Ray, 156
Baine, Rodney W., 63
Ball, Robert Morris, 39
Barrett, John Patrick, 109
Battle, William Robert, 88
Brewer, David W., 63
Brock, J. M., Jr., 109
Brown, Raymond Lloyd, 39
Burk, John David, 109
Bush, George R., 63
Carter, Richard Clarence, 156
Cartwright, Clifton Claude, 109
Causey, William A., 39
Chen, Ching, lygh, 39
Christian, Thomas W., 63
Conerly, Donald V., 63
Cook, Charles Alvin, 109
Cowen, George David, 156
Cross, John M., 39
Cunningham, Jerry Milton, 156
Dare, Daniel Paul, 109
Dawkins, Walter E., II, 15
DeCoux, Robert E., Jr., 15
Defore, Woodrow Wilson, Jr., 88
Farrell, George Edward, 207
Flood, John B., 39
Ford, William R., 39
Fouts, Anthony C., 39
Frame, Donald Wayne, 39
Friedman, Charles Alvin, 88
Frye, Wyndham Montgomery, 207
Gaines, Kenneth James, 110
Gamble, Hugh A., II, 207
Garth, William P., 63
Gemellaro, Vincent, 63
Gleaves, James R., 88
Gordon, Gary G., 64
Graves, Glen Robert, 39
Grenfell, Raymond F., Jr., 39
Groff, Gary H., 156
Guich, Charles J., 156
Gullung, William H., III, 207
Halbrook, John C., 39
Hale, T. Eric, 207
Heath, Bobby J., 40
Herrington, Robert R., III, 64
Holladay, Walter Robert, 88
Hopper, William Clayton, Jr., 156
Ingram, Fred H., 110

Irby, Henry E., 15

James, Edward Thomas, Jr., 207

Johnson, John Wilcox, 64

Johnston, James Harvey, III, 40

Jones, Daniel W., 88

Kapp, John Paul, 156

Keddy, David B., 157

Latham, Wilbur Darrell, 157

Lillard, Patrick Lynn, 15

Lipton, David E., 207

Lotterhos, William East, 207

Mangreim, Carole Lynn, 110

Marley, Bouldin A., Jr., 40

Mathews, Arthur Morris, Jr., 157

Mattieu, Donald E., Jr., 64

McClain, Eldon Duane, 207

McCloskey, John Joseph, 110

McFarland, Thomas R., 64

McMahan, Lynn, 88

McRaney, T. O., 64

Meadors, Marvin P., 64

Montgomery, Charles W., 15

Moses, Michael E., 157

Nash, Binford T., Jr., 255

Nelson, John C., 89

Newcomb, Martin M., 40

O'Neal, Kelly R., 89

Paine, Thomas David, 40

Parkman, Charles J., 64

Parks, Leon C., 207

Patel, Daksha M., 157

Payne, Joel G., Jr., 64

Peacocke, Ivan L., 89

Peters, William H., 255

Pham, Tuan Quang, 40

Pringle, Donald F., 40

Purdy, James J., 177

Rehak, Edward M., 255

Ricketson, Greer Homer, 157

Roberts, Anne A., 40

Routh, Anupam, 157

Rubin, Jack, 15

Sanders, Jane A., 64

Sanders, John R., 89

Sepulvado, Polly, 110

Shands, Thomas Andrew, 15

Sheen, Sidney Michael, 15

Shelton, Walter Towan, 208

Shirley, Stephen M., 40

Smith, Carol Ann, 157

Smith, Jason Van Alstine, 208

Smith, Robert E., 15

Smith, W. H., Jr., 64

Spruill, Faye G., 208

Stepp, Daniel J., 255

Sulser, Ralph E., 40

Sumrall, Doyle Frazier, 208

Talmor, Hanoeh, 40

Tarver, Russell Stovall, 208

Uhrmann, Susan B., 40

Velez, Hernando, 16

Venters, David B., 64

Vise, Richard Martin, 16

Voller, Robert Dale, Jr., 208

Wallace, William H., 64

Ward, Michael S., 40

Wells, Peggy J., 110

Williams, J. E., III, 64

Wilson, John Drake, 157

Mississippi Academy of Family Physicians

Dr. Ed Hill named president, 209-N

Governor Winter proclaims family doctor week, 109-N

Mississippi Baptist Medical Center

schedules cardiovascular seminar, 176-N

Mississippi Heart Association

names Dr. Walter Rose president, 176-N

sponsors tri-state scientific sessions, 58-N

Mississippi Hospital Association

says group purchasing cuts costs, 58-N

Mississippi Lung Association

leaders are recognized, 250-N

Mississippi Medicaid Commission (see also Medicaid)

reports fiscal 1979 operations, 42-N

seeks \$50 million increase, 249-N

Mississippi Medical Fraternal and Educational Society (MMFES)

(see malpractice)

Mississippi Medical Political Action Committee

physicians urged to join [Murphy] 245-E

Mississippi Public Health Association
annual meeting address [Cobb] *95
Mississippi State Board of Health
state health officer addresses national conference, 153-N
governor makes appointments to newly re-organized board, 153-N
Mississippi State Medical Association
address of the president [Gable] 148
Auxiliary — (see Auxiliary to MSMA)
Board of Trustees — conducts fall meeting, 13-N; has summer meeting, 202-N; invites nominations for MSMA-Robins Award, 227-N; names new officers, 123-N; members will attend AMA Leadership Conference, 37-N
Bucky Murphy joins headquarters staff, 38-N
Dr. Weems and Dr. Gilmore, AMA delegates, participate in radio interviews during AMA meeting, 227-N
former president Lamar Arrington dies, 58-N
Jail Health Project — sponsors receiving screening seminar, 57-N; announces Copiah jail will seek AMA accreditation, 107-N; conducts mental health workshop, 175-N and 209-N
Journal MSMA — reader comments on new cover design [Smith] 226-L
plans legislative activities for 1980 session, 37-N
plans malpractice seminar, 281-N
President's Page — [Gable] — "A Close Look at Political Involvement," 8-PP; "Let's Plan for a Great Convention," 32-PP; "Banquet Night at Annual Session," 54-PP; "FTC Broadens its Attack on Medicine," 84-PP; "All Good Things Must Come to an End," 102-PP
President's Page — [Moore] — "Escape from the Silent Majority Complex," 120-PP; "Government Involvement in Medicine," 150-PP; "AMA Meeting — Opportunity for Solving Problems," 172-PP; "Voice of Organized Medicine," 198-PP; "What Choice?" 224-PP; "Are You Involved?" 244-PP; "Election's Impact on Medicine," 274-PP
112th Annual Session — Council completes plans, 57-N; official call and program, 70-N; delegates elect Dr. Moore president, Dr. Triplett president-elect, 122-N; Howard K. Smith will be featured speaker, 57-N; Howard K. Smith tells members keys to solving nation's problems, 124-N; medical leaders discuss issues, 128-N; new president is active in medical organization, 129-N; report of activities, 123-N; special presentations highlight Delegates meeting, 127-N; summary of Delegates' actions, 126a-N
113th Annual Session — Council begins plans, 126-N; announces meeting schedule, 203-N
Mississippi Thoracic Society
recognizes leaders, 250-N

N

National Health Insurance (NHI)
can we afford it? [Mathews and Larson] *51
Democratic Party platform of 1980 advocates NHI, 220
Republican Party platform of 1980 opposes, 221
National Health Service Corps
boon or boondoggle? [Silver] *29
Nuclear Medicine
nuclear imaging of the heart [Ball] *23
Nuclear Waste
hospitals report no difficulties from closing of waste disposal sites, 17-N

O

Obstetrics and Gynecology
maternal death due to rupture of uterus during oxytocin stimulation [Godfrey] *117
Ochsner, Alton
discusses future of medicine at distinguished lecture series sponsored by Field Community Hospital, 155-N
Ophthalmology
intraocular lens implantation [Rayner] *145

P

Pankratz, David S.
death of Dr. Pankratz is reported, 250-N
Pediatrics
child abuse in Jackson, MS [Levy] *1
Dr. Jeanette Wilkins delivers Claud L. Batson Memorial Lecture, 14-N
Mississippi chapter of American Academy of Pediatrics conducts annual meeting, 13-N

Peptic Ulcer
abdominal scanning for retained gastric antrum [Sanders and Flowers] *143-RS
Perinatal Care
perinatal regionalization: it works for all of us [Morrison and Rhodes] *137
UMC authorized to seek CON approval for perinatal center, 249-N
UMC schedules perinatal seminar, 251-N
Personals
Abraham, George E., II, 38, 59, 231
Achor, James, 59, 109
Addison, Holland M., Jr., 205
Aden, William M., 205
Aldridge, John E., 16
Aldridge, Katherine S., 206
Alvis, Joel L., 16
Andy, O. J., 177
Arrington, George L., 231
Atkinson, Bruce E., 177, 205
Atwood, John G., 279
Bailey, Joe, 205
Balducci, Lodovico, 177
Ball, George, 177
Ball, Leonard, 279
Banks, Frank R., 177, 205
Barkley, Thomas, 205
Barnes, Helen B., 157, 205
Barrett, J. Patrick, 206
Bates, G. William, 59, 109, 157, 205, 254
Bearry, John H., 109
Beckman, William E., III, 177, 205
Biggs, Jack C., 231
Braddock, T. N., 279
Brent, Alvin E., Jr., 254
Broadus, L. Z., 279
Brock, Dewitt T., 231
Brock, Ralph, 135
Brooks, Thomas J., 254
Burnett, David, 231
Burnett, Robert James, 231
Burns, Janis E., 231
Burrow, Lamar, 279
Butts, Donald H., 177
Byrne, David E., 205
Byrne, George W., 205
Campbell, Guy D., 88
Carl, L. T., 205
Carnar, David V., 177, 231
Carruth, Larry W., 254
Carter, Thad C., 254
Chauvin, J. C., 279
Chauvin, Russel G., 231
Conerly, A. W., 177, 254
Cook, Clayton S., 254
Cook, James W., 206
Cook, John J., 88
Cornelius, Leland R., 231
Cotten, Milam S., 109, 205
Covington, Frank, Jr., 177
Craig, H. Vann, 109
Crane, Edmund H., 88
Cromartie, A. Dean, 254
Crosthwait, James, 158
Currier, Robert, 38
Davis, William A., 231
deBessonet, David A., 205
Dominici, Raymond, 135
Doolittle, Philip D., 135
Draper, Edgar, 38, 177, 205
Duckworth, Michael R., 231
Duffy, Patrick A., 231
East, William W., 135
Egger, John F., Jr., 231
Ehrich, Melvin, 279
Ellis, George H., 109
Ellzey, Howard W., 231
Estess, John M., 16
Evans, E. Warren, 254
Evers, Carl G., 59, 109
Fineburg, Steven B., 177
Flowers, W. Mel, 59, 88, 109, 205, 254
Flynt, Joel R., 254
Ford, John Robert, 38, 59
Freeland, Alan, 254
Gallant, Gary, 279
Gamble, Hugh A., II, 206
Gillis, W. R., 16
Gleaves, James R., 135
Goudelock, John Clifton, 279
Gonzalez, Maria I., 135
Goyer, Thomas E., 231

Gruich, Charles J., 254
Gruich, Frank, 16, 88
Guest, Roland P., 206
Gellung, William H., III, 206
Halbrook, John C., 206
Hamilton, Edward C., 38
Hamway, Sammy, 16
Hardy, James D., 16, 38, 135, 158, 177, 254
Hardy, M. D., Jr., 88
Harris, John E., 231
Hartcock, Martin B., 59, 88
Hartness, Stanley, 135
Hartwig, Geoffrey B., 254
Hatten, Karl, 254
Heath, Bobby, 206
Hebert, A. Foster, 279
Heckler, Frederick, 158
Hellem, Harper, 16, 38, 88, 254
Herman, Martin, 231
Herrin, Thomas, 16, 158
Hewson, Roy T., 38
Hilburn, William M., Jr., 231
Hill, J. Edward, 16, 279
Hodges, Lucien, 88
Hoffman, Edward S., 231
Holbert, Robert D., 16
Hoover, Jack C., 158
Hopkins, L. Gerald, 135
House, James R., Jr., 206
Houston, Thomas P., 254
Hughes, James L., 16, 38, 88, 177
Hughes, Wayne, 158, 279
Hutchinson, Richard, 135
Jabaley, Michael E., 38
Jackson, John, 59
Joe, David S., 231
Johnson, Samuel, 88, 231
Johnston, J. Harvey, Jr., 135
Keddy, David B., 16
Kellett, Boyd A., 158
Kellum, Herman E., 254
Kiley, John, 59
Kinsey, Herbert P., 109
Knox, I. C., Jr., 254
Laney, Charles H., 254
Langford, Herbert, 16, 38, 60, 88, 135, 158, 231, 254
Lanier, Douglas, Jr., 88
Lansden, Frank, 88
Leifer, Mark H., 279
Lewis, C. James, 177, 205
Lewis, Henry L., 135
Little, Robert A., 279
Lockey, Myron, 60, 135
Lotterhos, William E., 16
Lowicki, Edward M., 279
Makey, David A., 279
Manning, James O., 60
Marascalco, Charles, 16
Marascalco, John, 177
McDonald, Thomas J., 279
McFadden, John W., 231
McFarland, Thomas R., 88
McFarland, Wesley L., 254
McLain, Patrick G., 38, 206
McLeod, James N., 206
McLeod, John A., III, 206
McMillon, Joseph B., 206
Merrell, W. H., Jr., 16, 158
Milam, John B., 205
Mitchell, J. Dan, 16
Moffitt, Ellis M., 135
Montgomery, Charles W., 206
Moore, David B., Jr., 279
Moore, Paul H., Jr., 206
Morgan, John, 279
Morgan, Mallan G., 254
Morris, Toxey M., 135
Morrison, Francis S., 158
Morrison, John, 135, 158, 177, 231, 254
Neill, Karleen, 158
Nelson, Norman C., 60, 206
Nichols, Aubrey N., 177
Nichols, Richard A., 231
Norman, Joe, 38
North, Edward R., Jr., 279
Northey, Dan R., 254
O'Neal, Robert, 38
Orr, Edwin R., III, 279
Pace, Mary Ellis, 279
Pace, Samuel C., 206
Palmer, Michael L., 279
Parent, Andrew, 158

Parker, Judith G., 279
 Parks, Leon, 231
 Parks, Susan, 279
 Parvin, Steve, 279
 Patterson, W. J., 158
 Pharr, Richard W., 231
 Picklik, John R., 205
 Pittman, Kenneth P., 177, 205
 Powell, Joe, 279
 Prosser, Sidney, 279
 Purks, W. K., 254
 Purvis, George D., 60
 Purvis, John M., 206
 Raines, Oney C., 279
 Ratliff, Roger D., 205
 Rawson, Jack, 60
 Reid, Kenneth J., Jr., 206
 Reid, William F., 206
 Rhea, Charles S., Jr., 206
 Rodda, Thad, 279
 Rodgers, Debra Savage, 231
 Rogoff, Frederick D., 16
 Ross, Scott K., 16
 Ruvinsky, Marcelo J., 254
 Sandefur, John C., 135
 Sandifer, Fred M., III, 60
 Sanford, Robert, 158, 177
 Santangelo, A. J., 158
 Sartin, Jack, 279
 Schmidt, Frank L., 279
 Schreiter, Spencer L., 206
 Segrest, D. M., 16
 Seyler, Clifford Allen, 60
 Shands, Thomas A., 205
 Shannon, E. Linwood, 135
 Shaw, Rebecca D., 231
 Shaw, Thomas R., 109
 Shelton, Walter R., 60
 Shoemaker, J. H., 158
 Shuck, David B., 231
 Simmons, A. L., 206
 Smith, Carol Ann, 206
 Smith, George V., 16, 158, 231
 Smith, J. George, 254
 Smith, Robert R., 88, 254
 Spragins, William H., 16, 279
 Spruill, Faye G., 38
 Stepp, Daniel J., 88
 Stern, Charles, 231
 Stewart, William R., 206
 Streiffer, Richard H., 231
 Stripling, John R., 254
 Strong, William B., Jr., 206
 Suares, Robert Neal, 206
 Sudduth, E. P., 206
 Sy, Bertrand O., 232
 Tarver, Russell S., 206
 Thigpen, J. Tate, 16
 Tipton, Raymond E., Sr., 109
 Thompson, William B., 60
 Thornton, Bill, 60
 Truett, George W., 60
 Turner, Robert S., 232
 Turner, Thomas C., 60, 158
 Tutor, Forrest T., 279
 Tyler, Henry B., 232
 Walker, William E., 231
 Wallace, C. E., 158
 Watkins, Billy N., 16
 Watson, David, 60, 254
 Weems, Lamar, 38, 135, 177
 Wesson, Ray, 60
 West, Chester A., 206
 Wharton, George W., 206
 Whites, Barry L., 88
 Whites, Dayton E., 109
 Williams, John E., 38
 Williams, Ronald B., 60
 Wiser, Winfred L., 206, 232
 Wood, James P., 177

Physicians

advertising by physicians opposed in newspaper editorial, 34-E
 Dr. Morgan to head licensure board, 277-N
 GMENAC predicts physician surplus, 249-N
 lack of professional courtesy in consulting, referring, is deplored by reader [name withheld] 10-L
 Mississippi physicians have longer hours and lower fees [Mathews] 9-E
 should become involved in educational programs on safe use of recreational vehicles [Lockey] 103-E
 should communicate clearly [Zupko] 86-PM
 terminating the physician-patient relationship [Murphy] 56-PM
 urged to report pesticide poisonings, 87-N
 urged to participate in community and government activities [Moore] 120-PP
Poisoning
 physicians urged to report pesticide poisonings, 87-N
Political Action
 close look at political involvement [Gable] 8-PP
 government involvement in medicine [Moore] 150-PP
 MMPAC needs physician support [Murphy] 245-E
 nation must set priorities [Dabney] 199-E
 new administration — new hope [Mathews] 9-E
 political problem-solving [Dabney] 55-E
Postgraduate Calendar
 schedules published on pages 11, 65, 89, 112, 119, 161, 256

Practice Management Mailbox (see also Medical Practice)

consent requirements in the treatment of minors [Murphy] 12-PM
 doctor as personnel director [Downs] 105-PM
 fees and charges — ethical considerations [Murphy] 226-PM
 how long to keep records? [Murphy] 174-PM
 importance of checking references [Dowling] 133-PM
 keeping accurate medical records [Murphy] 36-PM
 negotiating personal contracts, 280-PM
 physicians should communicate clearly [Zupko] 86-PM
 procedures for releasing medical records [Murphy] 160-PM
 terminating the physician-patient relationship [Murphy] 160-PM
 time survey can help determine how long patients are waiting, 247-PM

PSRO

AMA plugs PSRO program, 228-N

Public Opinion

Gallup survey shows AMA credibility remains high, 107-N

Public Health

state health officer describes needs at national public health meeting, 153-N

R

Radiologic Seminars

CXCVIII: ultrasonography of the gallbladder [Hale] *4
 CXCLIX: improved thyroid uptakes and scans with iodine-123 [Emrick and Flowers] *27
 CC: obstructive jaundice secondary to carcinoma of the gallbladder [Barrett] *49
 CCI: cystic lymphangioma — a consideration in asymptomatic, massive, cystic splenomegaly [Ellison] *67
 CCII: shoulder arthrography [Weathersby] *93
 CCIII: solitary bone lesion from unsuspected renal carcinoma [Wade and Lawhon] *115
 CCIV: abdominal scanning for retained gastric antrum [Sanders and Flowers] *143
 CCV: CT in intracranial abscess [Pittman and Russell] *167
 CCVI: pancreatic arteriovenous malformation [Lawhon] *184
 CCVII: ectopic thymus [Coward] *217
 CCVIII: superior mesenteric artery syndrome [Burkhalter and Blumenthal] *240

CCIX: CT in orbital diagnosis [Pittman and Russell]

*262

Reye's Syndrome

Reye's syndrome [Gray and Ryan] *211

Rohins Award

MSMA Board invites nominations, 227-N

presented to Mrs. Jack A. Atkinson, 127-N

Rose, Walter H.

named president of Mississippi Heart Association, 176-N

Rural Health

federally funded rural health clinics: bonanza or boondoggle? [Mathews] 151-E

S

Safety

physicians should educate patients on safe use of recreational vehicles [Lockey] 103-E

Second Opinion

HEW's new campaign for second opinions [Mathews] 33-E

Shoulder

shoulder arthrography [Weathersby] *93-RS

Smith, Howard K.

featured speaker at annual session, 54-PP; 57-N
 tells MSMA members keys to solving nation's problems, 124-N

Spleen

cystic lymphangioma — a consideration in asymptomatic, massive, cystic splenomegaly [Ellison] *67-RS

colon obstruction secondary to adhesive splenomegaly [Didlake et al] *237

Surgery

colon obstruction secondary to adhesive splenomegaly [Didlake et al] *237

HEW's second opinion campaign [Mathews] 33-E

management of thoracic duct fistula following insertion of cardiovascular prosthesis [Maples et al] *233

spontaneous rupture of the esophagus [Defore and Netterville] *214

use of aspiration cytology in diagnosis of breast cancer [Martin] 152-E

T

Taylor, C. D.

elected president of Tulane Medical Alumni, 17-N

Thompson, James T.

paid tribute to, 278-N

Thyroid Gland

improved thyroid uptakes and scans with iodine-123 [Emrick and Flowers] *27-RS

Tumor

prolonged remission of metastatic rhabdomyosarcoma: the use of chemotherapy and nutritional support [Balducci and Steinberg] *181

solitary bone lesion from unsuspected renal carcinoma [Wade and Lawhon] *115-RS

Thymus

ectopic thymus [Coward] *217-RS

U

Ultrasound

ultrasonography of the gallbladder [Hale] *4-RS

use of ultrasound in diagnosis of obstructive jaundice secondary to carcinoma of gallbladder [Barrett] *49-RS

University of Mississippi Medical Center (UMC)

announces faculty appointments, 112-N

authorized to seek CON approval of perinatal center, 249-N

Dr. Blake authors electrocardiology text, 136-N

fall enrollment figures told, 228-N

schedules commencement, 107-N

schedules perinatal care seminar, 251-N

Urology

profile of the renal colic patient [Elliott et al] *163

Winter, William

makes appointments to health boards, 153-N

proclaims family doctor week, 109-N

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "MLB," Medico-Legal

Brief; "BR," Book Reviews; "AP," Auxiliary Page; "PM," Practice Management Mailbox. The asterisk (*) indicates on original article in the Journal.

B Balducci, Lodovico, *181 Ball, Otis G., *23 Barrett, Hoshall S., Jr., *49-RS Blumenthal, Bernard I., *240 Brandon, L. H., 10-L Brooks, Thomas J., III, 272-L Burkhalter, James L., *240 C Cobb, Alton B., 95-SA; 272-L Cowart, Mary Ann, *217-RS	G Gable, Gerald R., 8-PP; 32-PP; 54-PP; 84-PP; 102-PP; 148 George, Richard L., 35-BR Godfrey, W. E., 117 Gordon, J. O., *163 Gray, Ronald E., *211; *259 H Hale, Carl R., *4-RS I Izsak, E. Moshe, *259 K Kilgore, Thomas L., Jr., *233 L Larson, Lon, 55 Lawhon, Nancy C., *115-RS; *184-RS Levy, David, *1 Locky, Myron, 33-E; 103-E; 173-E M Maples, Michael D., *233 Martin, George H., 85-E; 151-E; 225-E Martin, Mrs. Ben F., 273-AP Mathews, Charles L., 9-E; 33-E; 51; 268 McMullan, Martin H., *233 Montgomery, C. R., *193 Moore, Paul H., 120-PP; 150-PP; 172-PP; 198-PP; 224-PP; 244-PP; 274-PP Morrison, John C., *137 Murphy, Bucky, 12-PM; 36-PM; 56-PM; 160-PM; 174-PM; *190; 226-PM; 245-E	N Netterville, Rush E., *214 Nicholas, William C., 55-L; 121-BR P Pass, Harvey I., *237 Pittman, Hilton W., *167-RS; *262-RS Platt, L. O., *163 Price, Beulah M., *171 R Raju, Seshadri, *237 Rayner, James W., *45 Rhodes, Philip G., *137 Roberts, Mrs. Curtis, 223-AP Russell, William F., IV, *167-RS; *262-RS Ryan, Nell J., *211 S Sammons, James H., 85-L Sanders, Jane A., *143-RS Silver, Patsy, *29 Smith, Edward E., *145 Smith, George V., 226-L Steinert, Martin H., *181 Sutherland, C. G., *192 W Wade, John D., *115-RS Weathersby, Patricia, *93-RS Wright, J. William, Jr., 245-E Z Zupko, Karen, 86-PM
--	--	---

TABLE OF PAGES

January	1 to 22	July	137 to 162
February	23 to 44	August	163 to 180
March	45 to 66	September	181 to 210
April	67 to 92	October	211 to 232
May	93 to 114	November	233 to 258
June	115 to 136	December	259 to 288

CLASSIFIED

TWO PRIMARY CARE PHYSICIANS and nurse practitioner needed for two primary health care clinics in rural Itawamba County, MS, operated under a DHHS-PHS Rural Health Initiative grant: (1) fully-renovated, newly equipped clinic and (2) new clinic to be built with FmHA/Rural Health Care program funds in late 1980. Program now provides full-time dental services. Service area approximately 18,750; full-time administrator and social worker. Salary negotiable. Prospects for financial self-sufficiency excellent. Contact: The Urgent Rural Needs, Inc. (TURN); P.O. Box 617, Fulton, MS 38843. Telephone (601) 585-3884.

THINKING OF RETIRING? MEDICAL DIRECTORSHIPS available, across the USA, any age physician, no fee, malpractice insurance paid, 35 hrs./wk, \$35 to \$40,000/yr., depending on location. List valid licenses, when able to relocate? Where? Please send resume, including telephone number, to: Fred V. Hrachovina, D.O., 1000 Second Avenue South, Minneapolis, MN 55403.

ESTABLISHED JACKSON PHYSICIAN has office space for lease; ophthalmologist preferred; share waiting room. Contact: Lynn D. Abernethy, M.D., 653 North State St., Jackson, MS 39201; (601) 354-5385.

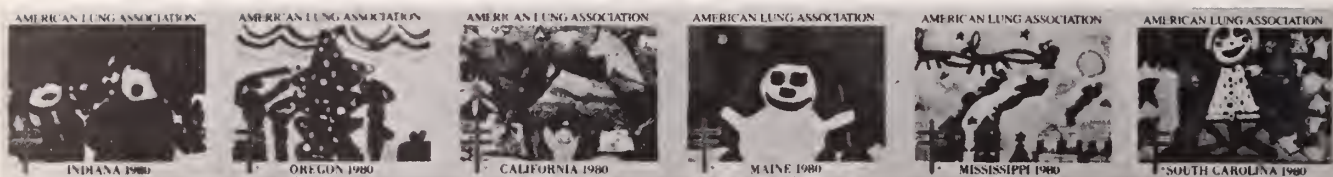
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Jan. 28, 1981
Holiday Inn Downtown, Jackson
Sponsored by MSMA Auxiliary**

Special invited guests are Governor William F. Winter, Lieutenant Governor Brad Dye, Speaker of the House C. B. "Buddie" Newman, their wives, and members of the 1981 Mississippi Legislature. Join Us.

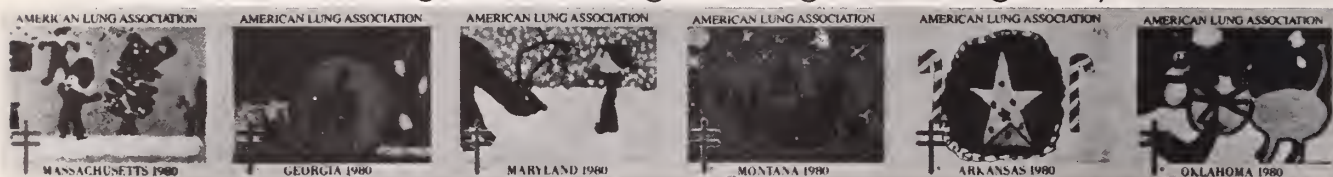
Index to Advertisers

Anderson-Clayton Foods	12	Miss. Medical Fraternal and Educational Society	11
Boeringer-Ingelheim Ltd.	282B, 282C, 282D	Parke, Davis	4
Boots Pharmaceuticals	6A, 6B, 6C, 6D	Premier Printing	14
Burroughs Wellcome	14B	Primos Northgate	266
Canton Exchange Bank	261	Riverside Hospital	18
Citizens Bank	3	Roche Laboratories ..	second, third, fourth covers, 3, 282A
Darkroom, Inc.	276	Smith, Kline and French	14A
Harreld Chevrolet-Oldsmobile	3	Wyeth Laboratories	10A, 10B, 16, 17
Integrated Resources	10	Thomas Yates & Co.	6
Eli Lilly and Company	8		

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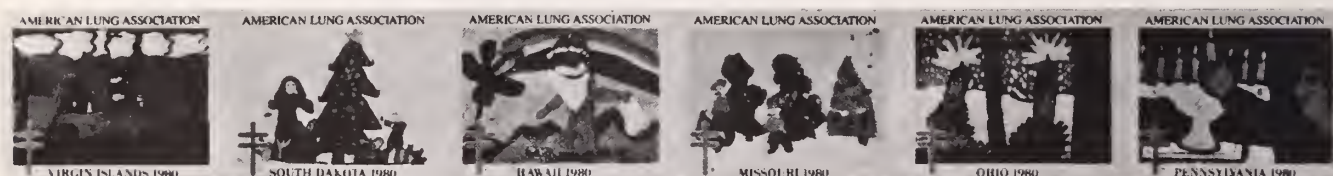
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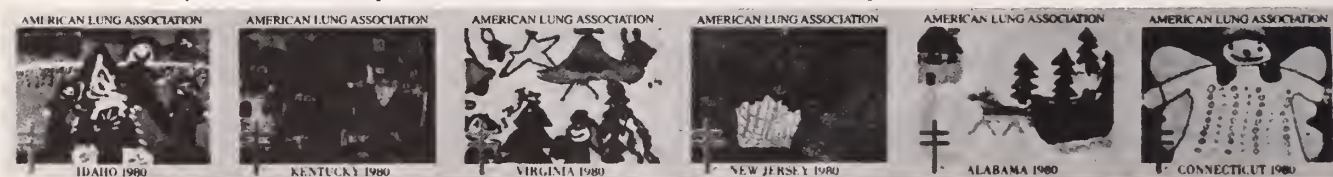
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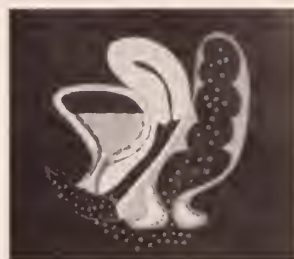
ROCHE

For recurrent attacks of urinary tract infection in women

BactrimTM DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice

- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morgani*. **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache,

peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

***Pneumocystis carinii* pneumonitis:** Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

N.Y. ACADEMY OF MED
2EAST 103RD ST
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10029

Her next attack of cystitis may require the BactrimTM 3-system counterattack



Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of

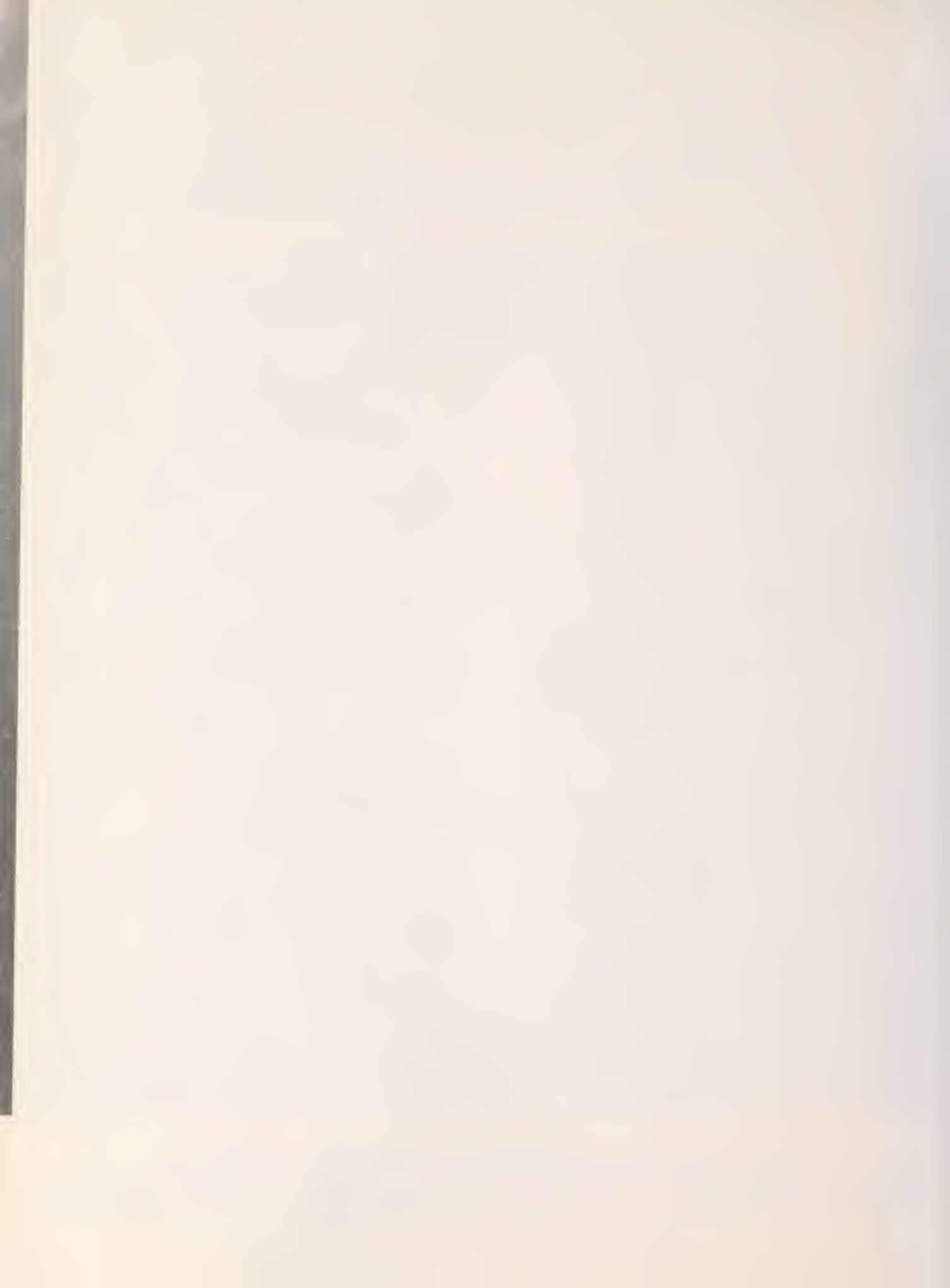
Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.







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